Statement on Aging and the Aged

A Discussion Paper Prepared by

The Nova Scotia Senior Citizens' Secretariat

Nova Scotia

Province of
Nova Scotia

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INTRODUCTION

SIGNIFICANCE OF SOCIAL POLICY STATEMENT FOR AGING AND THE AGED

Social programs to assist the elderly have become a major part of the business of government at all levels - federal, provincial and municipal. The private sector continues to be deeply committed and involved, and concern for the elderly is high on the list of priorities of a number of voluntary agencies.

The elderly themselves have emerged in the last decade as a powerful force. They have an inherent commitment to improve public programs and services and, in some cases, they have become service providers. This trend is encouraging because in the long run it is likely to result in services and programs being more relevant to the real needs and aspirations of the senior population.

Our primary task is to identify and understand the major issues facing us in planning social policies to assist those in the population who are aging. The decline in the birth rate and the lengthening average life expectancy brought about by improved health services and other social improvements mean that in the foreseeable future we will continue to have a rapidly aging population. The significance of this change is obvious. From a financial point of view, there will be increasing pressure on government to set aside larger service budgets for seniors. At the same time, unless we plan for considerable changes in the composition of the productive work force, we will have fewer people contributing to the available resources. That situation in itself, if not properly managed, could produce tensions that are inimical to a healthy society.

The improvements in health and social services achieved over the past forty years have been a blessing for all people - especially the aged. However, these improved services have brought about new problems. How will we provide for the growing number of very old and chronically ill seniors? What use will we make of institutional care? How will we find sufficient funding for new home care programs? Will improved health services and prolonged life expectancy eventually lead to a deterioration in the quality of life? These are serious questions and they confront us now.

Technological advances such as the automobile and rural electrification, for example, have brought untold benefits to rural Nova Scotians, especially the elderly. But each advance, while adding to the comfort and enjoyment of life, has also added greatly to the cost of living and to the level of income required by seniors to maintain standards reasonably comparable to those of the rest of the population.

Increasing numbers of elderly people will inevitably mean increasing pressure on elected officials at all levels to extend existing services and to develop new services for seniors. While everything we have accomplished to date in developing programs and services is commendable, a society committed to social justice must also be concerned about the capacity of its citizenry to help itself, separate and apart from government. Social programs, necessary as most of them are, should not replace personal responsibility and initiative nor should they detract from the individual's innate capacity to manage his or her own life in concert with family, friends and community. We have therefore emphasized throughout this paper that in developing social programs, personal and community initiative should be maintained and strengthened, and that government should encourage seniors and communities to seek out ways of promoting self-help, thus encouraging the private sector.

Nova Scotia is one of the oldest of the British colonies in the Canadian confederation. Inevitably then, it has always had a larger percentage of seniors than the newer parts of Canada, whose population is made up of a larger percentage of in-migration. During the early part of this century this imbalance was aggravated by a large migration of young people from Nova Scotia to the United States and to central and western Canada. There are some indications now that this tide is reversing but the change will not likely be sudden or dramatic.

It would be easy to face problems only as they arise. Unfortunately, the very nature of social problems makes that an ill-advised expedient. Most health and welfare programs, once initiated, tend to be irreversible. Like the poet phrased it so well in the Rubyiat of Omar Kayam, one might wish to shatter the

Health and Welfare structure to bits and remold it nearer to the heart's desire, but that is not feasible nor is it likely to happen. We seldom discard what we have; we simply add new programs and make slight adjustments. Social planning and long-term social policy direction are therefore needed urgently for these costly and rapidly expanding health and welfare programs.

PROPOSED STATEMENT ON AGING AND THE AGED

The Speech from the Throne delivered at the opening of the First Session of the 53rd General Assembly of the Province of Nova Scotia stated the following:

> My Government looks forward to receiving three reports this year related to senior citizens and retirement. The Royal Commission on Pensions created in 1981 to investigate the adequacy and the effectiveness of pensions in Nova Scotia is expected to place recommendations before the Government later this year. The Senior Citizens' Secretariat has been charged with the responsibility for developing a Comprehensive Statement on Aging, to guide future government policy and strategies as the proportion of senior citizens in our society grows. The Nova Scotia Senior Citizens' Commission will consider and report to government on retirement age.

ORGANIZATION, FORMAT AND PURPOSE OF STATEMENT

This is a discussion paper prepared with the thought in mind that at least three sectors of the community have a duty and responsibility to respond. The first sector is the elderly who are directly affected by government programs; they should have some say in the form these services take and the way they should be delivered. The private sector, including business, industry and voluntary agencies concerned with aging and the aged should also be concerned. Finally, the government departments directly responsible for coming to grips with most, if not all, of the issues presented herein should be expected to respond. Our primary purpose then, is to provide a document which will encourage discussion and involve as many Nova Scotians and organizations as possible - including government - in a lively and productive debate concerning the quality of life they want to see developed in Nova Scotia for our senior population.

Chapter Three contains basic demographic information. We have tried to keep statistics and tables to a minimum, believing that more extensive statistical information would serve no useful purpose. We know only too well what is likely to happen in the next two or three decades with respect to our senior population. What is critical to our decisions are the kinds of social policies government and the private sector will encourage and support.

Points for Discussion are elaborated in Chapter Six. On some of these points there may be a clear concensus. The direction government and the private sector should take on others may not be so obvious. Where there is a concensus, we trust those government departments concerned, federal and provincial, will respond appropriately and citizens and communities will shoulder the burdens and responsibilities that properly belong to them. Where there is no concensus, we hope Chapter Six will stimulate discussion and eventually lead to an informed public opinion.

The other sections of the Statement deal with the relationships of the Secretariat to other Departments of Government, definitions, principles and assumptions, a brief description of programs provided by the provincial government which benefit seniors and finally, the roles of the family, the private sector and municipal and federal governments.

For those interested in the historical background of these programs and services, there is a brief historical overview in the Appendix.

It is not possible to ignore pensions and retirement income in a comprehensive statement such as this, and we will deal with this subject as an integral part of the whole. Specific and far-reaching recommendations are contained in the Report of the Nova Scotia Royal Commission on Pensions.

The Senior Citizens' Commission is studying, and will report to government on retirement age. As with pensions and retirement income, we cannot ignore this social policy issue but it will not be considered here in any detail.

It will become obvious to the reader that we will, out of necessity, address questions that relate to the role and responsibility of the individual, the family, the community and government, in shaping a just and compassionate society. These issues are fundamental, and universal agreement with respect to the directions we should take is bound to provoke sharp disagreement. The blind men of Hindustan, feeling the elephant, had a wide range of impressions concerning what the elephant was really like. Simply because we may have widely divergent views concerning what we should do to improve the quality of life for our seniors does not mean some or all of these views are wrong. In truth, each person tends to appraise the issues from his or her own special bias or background of experience; only through dialogue and the sharing of views can we hope to find better answers to the questions.

Obviously, if new services are to be provided and if solutions are to be found for some of the issues that confront us, both the federal and provincial levels of government will have to be involved administratively and financially. That, of course, becomes central in these times of increasing costs and restricted budgets. Perhaps the overriding issue relates to where government will find the resources for the implementation of new programs and the extension of existing services.

Speaking at a Press Conference on September 6, 1978, the Premier, the Honourable John M. Buchanan, referred to senior citizens as follows:

> Among our senior citizens we find lifetimes of experience, education, knowledge and wisdom. We must encourage those who are able, and those who are willing - and I know there are many - to continue to use their acumen for their benefit and the benefit of society as a whole. We must not lose sight of their achievements and of their ability still to achieve ...

The Premier went on to say:

> We believe that government must be compassionate towards those of our people who want to help themselves but cannot shoulder the burden alone. We believe that this help can be provided without imposing intolerable costs on our citizens.
>
> Referring to costs in the same statement, the Premier said:
>
> It is important to bear in mind that the expansion of existing programs and the development of new programs depends on our ability to create new wealth in Nova Scotia ...

We would be unduly optimistic to expect immediate solutions and implementation of new services either by the private sector or by the provincial government. The development of new prgrams that are required will have to extend at least over the next decade, if not longer. Social reform will have to match the available resources and the needs of the Nova Scotia economy. The same restriction applies to Canada as a whole.

There is another cogent reason why we should view the new and existing services needed for our aging population as constituting a long-term plan. Voluntary community involvement in the provision of services for the aged and the aging is a key element in most of the new services that are needed in Nova Scotia for our aging population. That can only be achieved over the long-term.

We hope this paper will, in stimulating discussion, eventually help Nova Scotians to reach a concensus which will be good for the future of our beloved province.

References

1 Report of The Royal Commission on Pensions, Halifax 1983.

CHAPTER ONE

THE SECRETARIAT - RELATIONSHIPS

In February 1980, the Honourable Jack MacIsaac, Minister of Municipal Affairs and Minister in Charge of the Nova Scotia Housing Commission, announced the formation of a secretariat on aging in the provincial government. Legislation was introduced at the 1980 Session of the Nova Scotia Legislature providing for the establishment of the Secretariat. The Act designated the Ministers of Social Services, Health, Municipal Affairs and the Minister Charged with the Administration of the Housing Development Act as constituting the Senior Citiznes' Secretariat with the Governor-in-Council having the authority to add other persons as might be determined from time to time. The Secretariat came into being April 1, 1980.

The Minister of Education and the Minister of Culture, Recreation and Fitness were added to the membership of the Secretariat on August 17, 1982. These additions provided an essential new dimension to the work of the Secretariat, since these departments administer important programs of interest and benefit to seniors.

The Act states that the object and purpose of the Secretariat is to facilitate the planning and development of services and programs for senior citizens. This may be accomplished by coordinating plans, policies and programs presented by departments of the provincial government and by developing plans, policies and programs for and with the responsible departments of government and other provincial bodies such as the Nova Scotia Senior Citizens Commission and voluntary senior citizens' groups.

The discharge of these duties and responsibilities requires a close working relationship with the federal and municipal levels of government and the private sector so that duplication and overlapping can be avoided, program priorities decided upon, and, most important of all, services to seniors maximized, having regard to the resources available to all levels of government.

Governments, which have become large and highly specialized in the post war years, are organized and discharge legislative and program responsibilities through departments. Each department is assigned specific responsibilities, legislative and otherwise, so that at least in theory few problems should arise from duplication and overlapping jursidications. In fact, it is becoming increasingly difficult to define specific departmental responsibilities clearly and precisely with respect to problems affecting age groups such as seniors, children and youth, and where a broad spectrum of professional services is requisite to the development of these programs. Home care is an example of a service which involves at least two departments of government - Health and Social Services. The Department of Health provides and supervises nursing care in the home. The Department of Social Services is responsible for homemakers and this province-wide service is funded through that department. Home care for the elderly, in addition to nursing care in the home and homemakers, requires a number of related professional services not yet developed in any extensive way in our province and therefore not yet assigned by custom or tradition as the responsibility of a specific department of government. Rehabilitation and day care services for the elderly are examples of services that should be an integral part of a home care program but which, to date, have not been developed except in the Halifax area. How will a comprehensive home care program be coordinated having regard to the specific tasks and responsibilities carried out by the Departments of Health and Social Services? In general terms, how do we cope with the problems inherent in the overlapping jurisdiction and responsibility of specific government departments?

Overlapping responsibilities pose serious problems for the user of services who very often does not have the knowledge and experience required to cope with the system. The Secretariat has operated for four years and receives an inordinate number of calls from seniors and their families looking for advice on how, when and where they should approach various levels of government.

These examples and comments illustrate the need for a body such as the Cabinet Committee comprising the Secretariat. The obvious role of the Secretariat is not to become another government department that administers

programs, thus increasing the jurisdictional problem, but rather it should facilitate, enable and help existing government departments to develop programs and provide services for seniors.

The provincial Department of Social Services, because of its traditional role and legislative mandate, has always been expected to assume major responsibility in providing services to seniors. The sixties and the early seventies were times of rapid economic growth and expanding budgets; it was possible then to develop a number of new programs in Health, Social Services and Housing.

The Nova Scotia Social Services Council was established in 1970 to encourage citizen involvement and participation in the development of social policy; it serves in an advisory capacity to the Minister of Social Services. By 1972, a Commission on Aging was formed because aging and the aged had become a central theme in social planning. It was expected to work in close conjunction with the existing Council. This commission, the Nova Scotia Senior Citizens' Commission, advises the Minister of Social Services on all matters relating to seniors. The development of these advisory bodies in the broad field of social services and aging was a response to the obvious need for citizen input in policy making when new programs were developing at a rapid pace.

Times have changed as have the social and economic climates in which health, welfare and housing programs are now being provided. We are not experiencing, nor are we likely in the near future to experience, the rapid growth and expansion of services that prevailed in the late fifties, the sixties and the early seventies. What confronts us now is the need to develop more efficient and cost-effective services with the resources at our disposal. Where new services are being planned we have to be very sure they meet priority needs and are likely to be socially beneficial and effective over the long-term. These changes underline the necessity of a close working relationship between the community and the Secretariat.

It is important that we draw a clear distinction between the role and function of the Secretariat and that of the Senior Citizens' Commission. The concept of an advisory commission is based on the thesis that there should be citizen input from all parts of the province and from as broad a spectrum as possible of seniors receiving government services. The Senior Citizens' Commission holds public hearings regularly and rotates meetings throughout the province. At the moment, it has a membership of 20 seniors and is representative of a variety of interests geographically and occupationally.

Operating as it does within the structure of government, the Secretariat obviously performs an entirely different function. Coordination of the various programs emanating from departments is, as already stated, the principal function. The two bodies, in this sense, complement one another. The Commission provides the Minister of Social Services with citizen advice covering the broad field of aging and the aged, and this gives the Minister a unique opportunity to bring these views to the Secretariat. If the Commission were not operative, this listening post would not be available to the Minister and thus to the Secretariat. Likewise, without the Secretariat, the Commission would not have available to it the administrative and organizational structure required to involve departments of government other than Social Services, to which it is advisory.

The Chairman of the Commission attends all meetings of the Secretariat as an active participant. In the same way the Coordinator of the Secretariat attends all meetings of the Commission. In this way, both bodies are fully aware of what is being planned and are mutually supportive and helpful to each other.

CHAPTER TWO

PRINCIPLES AND ASSUMPTIONS

Richard Splane, in his study of social welfare in Ontario entitled Social Welfare in Ontario 1791-1893, refers to the fact that social welfare is an ill-defined 20th century term and that it is not easy to stake out its boundaries.[1] It is equally difficult to define Social Services. Joanne C. and Francis J. Turner, writing in a book entitled Canadian Social Welfare, define social welfare as "a network of legislation, policies, institutions, resources and services that have to be developed to insure that citizens will have access to those materials, services and resources of society that will permit them to develop their potential as individuals in a manner acceptable to them with due regard to the rights of others."[2]

The Turner volume states that social services is a term mistakenly used as a synonym for social welfare and that it should be used to describe the network of agencies and institutions that constitute the service component of the social welfare structure. Viewed thusly, social services is, in fact, a structural arrangement through which the policies and legislation of social welfare are implemented. Social services, then, is an apt name or designation for a department delivering social welfare programs.

The term "social services" is often given a broader meaning and used to include health services, labour legislation, housing and educational services. The British, for example, have used the term to include programs relating to health, education and housing. The Dutch consider labour legislation and income policies under the broad heading of social welfare. The American federal system, until recently, had health, education and welfare grouped together under a single Cabinet Minister responsible to the President. The student of public administration tends to think of these services and programs as falling under the broad heading of Human Resource Services, and public pronouncements, especially when critical in respect to government spending, tend to lump all of these services together.

In this paper, we will follow the Turner definition and social services will mean those services being provided or which should be provided through a Department of Social Services.

The welfare state, which developed in the 20th century and especially during the years immediately following the Second World War, became necessary for the preservation and protection of society because of sweeping social and economic changes in the Western World. Industrial expansion, the rapid growth of urban populations, and the extreme mobility of Canadians created problems for which income support programs were a necessity. Unfortunately, society has very often adopted the attitude towards the welfare state that if a little is good then more is better. Because it is difficult or impossible to envisage the complete satisfaction of all human needs and wants, it has therefore been difficult or impossible to define the limits of what the welfare state should encompass in terms of specific income transfers, income maintenance payments, housing programs, health services and government intervention.

We really have limited appreciation and understanding of what long-term effect the welfare state will have on such issues as freedom, personal initiative and personal well-being. Insofar as we consider these fundamental issues, we waffle back and forth between approval in times of affluence and negative criticism and soul searching when the economic tides are running against us. We are going through one of these ebb tides at the moment in which there appears to be disillusionment with the welfare state; in the United States, for example, the federal government is attempting to cut back on health and welfare programs. Other countries, such as the Netherlands, that have gone much further in developing a modern welfare state than either the United States or Canada are also seriously reflecting on the shape the welfare state should take, considering the grave social and economic issues that confront them at the moment. It follows, then, that a policy statement concerned with long-term planning for aging and the aged and the role of government requires a careful examination of issues that are the product of government intervention in the lives of senior citizens and the family.

Many social welfare programs in Canada have built-in disincentives. Some of these programs have become sacred cows, not to be tampered with except by incurring the wrath of this or that pressure group. Others have been legislated because we have been shortsighted, or have lacked knowledge. Still others have served to provide short-term solutions which, in the long run, have created more new and unwanted social problems than they have ever solved. Some of the disincentives can only be curtailed by incurring administrative costs that would be insupportable.

The questions that we have to ask are not at all obvious. Having posed the questions, the answers are certainly far from obvious. If we are serious about improving the quality of life for all our seniors, we have to be concerned about the long-term effect of government intervention on the lives of people. Why should the state provide health and welfare services? From the point of view of the welfare of the individual, is there a limit to what the state should provide? What position should we take with respect to universal and selective programs? Is there a distinction to be drawn between programs that provide money payments and those that are confined to the provision of services? Are there some programs that should properly be community based and developed only through community organization and initiative? Should government support programs financially even if they are managed privately? If the mark of a healthy community is its capacity to be independent and to help itself, to what extent, if at all, do health and welfare programs make people and communities dependent on the state?

One central question pervades all of the above - how much can we afford? We have been asking this question in Nova Scotia for the past 50 years. The only satisfactory answer in a parliamentary democracy is that government can afford what the government of the day decides it can properly allot to the human resource sector considering its available revenues and political commitments. This leaves unanswered the question of what portion of the human resource budget will be set aside for the component parts of that sector - health, social services, education, housing, and culture, recreation and fitness. When these decisions are made, there has to be a further decision as to what portion of the

budget allocated to each department will be set aside specifically for programs and services for the aged. There is no slide rule answer to these questions and there is no answer that will satisfy the government administrator who may view social priorities from one perspective and the social activist from quite another.

From the vantage point of peace, order and social stability, there is a strong validation for housing, health and old age security programs. There are, of course, other imperatives, not the least of which is our deeply rooted Judean-Christian heritage of caring and concern for all humankind, especially the weak and powerless in our society.

There are sound economic arguments for society providing income maintenance programs, transfer payments and health services. One of the reasons for the introduction of Family Allowances in the forties was economic as well as social. Certainly the current recession and decline in economic well-being of Canadians would be much worse if it were not for the economic support that is being provided through Old Age Security, Unemployment Insurance, Family Allowances, Family Benefits, Social Assistance, the excellent health services which Canadians enjoy, and government interventions in housing. Remove these and our economic situation would not be greatly different from what it was in the thirties when these income support programs and services were totally lacking.

It is difficult for a government to substantially change or do away with a program providing public benefits once that program is instituted or set in motion. The longer the program is in effect, the more difficult change or revision becomes. Vested interests are built up on the part of the recipients and the dispensers of the service so that government departments and Ministers have great difficulty in altering programs even if, from a rational point of view, the new proposal seems to be more effective. This is one of the reasons why governments hesitate to undertake anything new unless there is ample evidence and proof that it is likely to serve a useful purpose in the foreseeable future. "There can be no temporary or short term program of benefits dispensed by government."

We assume that, apart from any defined constitutional responsibility, there are certain program responsibilities which can best be carried out by specific levels of government. Basic universal income security, as illustrated by Old Age Security and the Canada Pension Plan, can best be provided by the federal government. Because such payments can only be designed to provide for average need across a continent with widely different living standards it follows that there may have to be supplementation programs at the federal, provincial and/or municipal level. There are other programs such as home care which are service oriented and can best be managed at the community level. Obviously, if we are to maintain reasonably uniform standards and levels of service across Canada there has to be a generous degree of federal cost sharing in provincial and community based services such as health services and home care. By the same principle, provincial financial support and encouragement of municipal and voluntary services such as home care are essential.

In the last two or three decades, government at all levels has been moving towards the decentralization of services so that they are available as much as possible at the local level. There are several reasons for this. The public served by a program prefers to be in a position where communication with those providing the service is convenient and practical. This can only be achieved when services are local and highly visible. The other factor relates to efficiency. When services are far removed from the people needing them, there is a danger they may become irrelevant to the real needs of the people served. This leads to waste of resources and frustration for all concerned.

The "principle of right" has become entrenched in most of our income maintenance programs and, in some cases, this "right" is given practical effect through appeal procedures which serve to protect the client from unfair or arbitrary administrative decision. We have come to recognize during the last two decades that if these costly and all encompassing programs are to be adequately administered, the "rule of law" should apply. The application of the "rule of law" leads to the principle of "right" if all the requirements for eligibility defined in the law are satisfied. The principle of "right" may be enshrined in legislation but, practically speaking, it is ineffective unless there

are either administrative or judicial structures available to the individual applicant which are

- readily accessible
- inexpensive, and
- unbiased.

Finally, machinery should be provided for a review to insure that justice is done.

The Ombudsman provides an effective and objective review body. If parliamentary democracy works as it should, the elected legislative member serving the constituency in which the applicant resides is a most appropriate person to insure that there is equity and justice in the decisions made by the administrative bodies for which the government and legislature must bear ultimate responsibility.

The principle of "right" is a more dignified and equitable basis for the provision of health services and income maintenance programs by government than humanitarian or economic arguments. The latter are not always dependable. In modern society the "right" to a floor or base of financial support and adequate health services is the only humane and practical answer not only for seniors but for everyone.

The role of the family, the private sector, and local government and certain assumptions we make regarding these institutions will be examined in detail in Chapter Five.

References

1. Richard Splane, Social Welfare in Ontario 1791-1893. (Toronto: University of Toronto Press, 1965) Introduction.

2. Joanne C. Turner and Francis J. Turner, Canadian Social Welfare, (Don Mills: Collier MacMillan Canada, 1981) p. 3.

CHAPTER THREE

DEMOGRAPHIC INFORMATION

The phrase "population aging" means the increase of older people in a population. In this paper, we define older people generally as those who are 65 or older although, in a few cases, we refer to age 60 as older.

The Specific Senate Committee on Retirement Age Policies reported in 1979 in a volume entitled Retirement Without Tears.[1] The opening paragraph in that part of the report concerned with demographic trends is sufficiently concise and pertinent to the Nova Scotia situation to be reproduced here.

> The aging of the Canadian population - the greying of Canada - is a demographic fact. The Canadian population is growing older and will continue to do so into the next century as those aged 65 and over become an increasingly larger segment of the total population. Concern has been expressed that this aging will strain the Canadian economy because it could mean substantial increases in the future tax rates on earned income in order to pay for the retirement income of the elderly. These demographic or population trends are therefore extremely important because of their possible effects on the economy and the way Canadians live.[2]
>
> The Canadian Governmental Report on Aging[3] made the following statement:
>
> There were roughly 3.2 million Canadians at least 60 years old as of June 1, 1980. Of this figure about 2.3 million were aged 65 and over. If Statistics Canada's projections are reasonably correct, the turn of this century will find some 4.5 million Canadians aged 60 and over, and 3.4 million within this group will be at least 65 years old. By 2025 when most of the baby boom generation will be at least 65 years old, about 5.5 million Canadians will be aged 65 or more (barring any catastrophe between now and then).
>
> Especially rapid growth is expected for the population at least 80 years old between 1980 and 2000. There were roughly 436,000 such Canadians at mid-1980, and they should be at least 777,000 strong at the end of this century.
>
> By the year 2000, nearly 12 per cent of Canada's population is expected to be at least 65 years old and that would be an increase of two percentage points over the 1980 value of 9.5 per cent. Whether

> population aging will accelerate in the early years of the next century is at present uncertain. The chief source of uncertainty results from the inability to be confident about what the children and grandchildren of the baby boom generation will do with regard to family building.[3]

The report continues:

> One of the most striking features in the changing profile of Canada's older population is the substantial and growing imbalance in the number of men and women. In the first half of this century men outnumbered women slightly within the older population. Since 1961 women have been the more predominant of the two sexes in the population aged 65 and over. The Statistics Canada projections envisage continued increases in the female predominance within the older population.
>
> There is a steady rise in the ratio of men to women in the older population, starting with the largest urban centres and moving towards the small towns, and then to the rural non-farm areas and rural farm areas. In 1976, urban centres of 500,000 or more in population had only 66 men per 100 women in their aggregate population aged 65 and over (the national figure was close to 78 men per 100 women aged 65 and over). Both the rural non-farm and the rural farm areas had more men than women in the older population.[3]

Following up this general statement the report goes on to analyze the make-up of this group of older women.

> Over half of Canada's women aged 70 and over are widows. In sharp contrast, less than one quarter of the men in this age group are widowers. Also, the proportion widowed among women aged 70 and over increased slightly between 1961 and 1976, whereas among men the corresponding proportion declined. Rates of remarriage among older men who have been divorced or widowed have been rising gradually.
>
> Women living alone comprise a major segment of the households headed by older people. The rate at which older widowed or divorced women have opted (either by free choice or by "unavoidable necessity") for living alone has increased substantially since the early 1960's. Among women aged 65 and over, the proportion living alone has increased from about 15 per cent in 1961 to nearly one third in 1976. It should be noted, however, that once the age of 80 is reached the propensity to live alone declines sharply and there is an increasing resort to "collective households"[3]

Referring to the health problems the report states:

The tendency for health impairments and disability to be more prevalent among senior citizens, especially those over 74 years of age, than in the rest of Canada's population is strongly confirmed by the data just recently published from the 1978-79 Canada Health Survey. These data show that days of disability, percentage of population having limitation in major activity and percentage reporting at least one health problem, among those aged 65 and over, are far above the national averages. The highest proportions are observed in the population aged 75 and over.

Directly related to these patterns of reported health impairment and disability is the substantially greater than average use of hospital and medical services in the older population. Once again, the peak health service utilization rates occur above the age of 75.5.[3]

The following comments are made in respect to income, home ownership and labor force participation.

Senior citizens comprise a group with an unusually high concentration of people with low income. This is particularly the case among unattached older women. About one half of the income of older unattached women comes from the Old Age Security and Guaranteed Income Supplement payments. Even among older men this is the largest single source of money income.

The older population has higher than average home ownership rates but they are more likely to own homes built before 1945 and the median value of their homes is substantially below the overall median value of all dwellings. Ownership of facilities such as automatic washers, automobiles and record playing equipment is below average for households headed by older people; however, the gap is very narrow for television ownership.

The labour force participation rates of men aged 55 and over have been in decline since the middle of the 1960's. In contrast, women aged 55-64 have shown rising labour force participation rates between 1966 and 1980 and the rates for women aged 65 and over have decreased by less than two percentage points. Within the older age group, the labour force participation rate is by far the highest for men and women aged 65-69, and it drops off rapidly after age 70.

Opportunities to work part-time are very important to employment of senior citizens. In 1980, 25 per cent of employed men and 47 per cent of employed women aged 65 and over worked part-time, compared to only three per cent of employed men and 24 per cent of employed women aged 55-64. From 1971 to 1980 the per cent of older employed people working part-time increased slightly.[3]

In 1981, the percentage of people in Nova Scotia who were 65 or older was 10.9% compared to the national average for Canada which is 9.7% (see Figure 1, Table 1). Out-migration of young people to the United States and other parts of Canada during the first part of this century served to keep the Nova Scotia percentage of older people low in comparison with the national average. Nova Scotia's percentage of 10.9% is exceeded by Manitoba, Saskatachewan, and Prince Edward Island. Newfoundland with a relatively high birth rate had the smallest percentage of seniors in 1981.

On the basis of population projections up to the year 2001, the percentage of seniors in Canada is expected to increase from 9.7% to 12.3% or by approximately one million persons (see Table 1).

The Baby Boomers born from 1940 to 1970 will begin to reach 60 years of age by the year 2000. The full impact of these post war births will be felt in the period 2001 to 2031. It is estimated that by 2031 the Canadian percentage of 9.7% will almost double, increasing to approximately 18%. According to Victor Marshall in his book Aging in Canada - Social Perspectives, the total number of seniors is projected to increase from the 1981 total of 2,360,985 to approximately 7,000,000.[4]

Projections as far ahead as 2031, should be taken as a general indicator and little more. There are a great many unforeseen factors which over a half century could radically alter such long term projections.

For the two decades 1981 to 2001, the projected percentage increase in seniors 65 years of age and over in Nova Scotia is 14.4% which would increase the 1981 senior population of 92,560 to 106,900 in 2001. The comparable Canadian percentage increase is comsiderably less. The major reason for this disparity relates to out-migration from Nova Scotia in the first half of the century, especially from 1920 to 1940 when employment opportunities in the Atlantic Provinces were limited.

Approximately nine per cent of Canada's population aged 21 and over was 65 years of age and over in 1881 (see tables 3,4). That percentage almost tripled from 1881 to 1981 and is now about 25%. It is also worth noting that about 16% of Canadians 21 and over had reached the biblical age of three score years and ten in 1981 and that this age group as a percentage of Canadians age 21 and over had increased threefold over the century from 1881 to 1981. Since the working population, generally speaking, is over 21 years of age and the youth dependency group is, for the most part, under 21 the percentage of individuals aged 70 and over is significant as a percentage measure of the volume of dependency in the aging sector of the population.

Between 1901 and 1981 the percentage of Nova Scotia's population aged 70 and over increased from 4.2% to 7%, which in comparison with the other provinces might be considered a moderate increase (see Table 5). Manitoba's percentage, for example, increased from 1.3% to 7.8%, or sixfold. The Ontario and Quebec percentages doubled for the same period and the Alberta and British Columbia percentages increased approximately fivefold. In 1901, 4.2% of our population was aged 70 and over and only Prince Edward Island had a higher percentage at 4.3%. This fact coupled with the out-migration of young people already referred to probably accounts for the moderate increase in the Nova Scotia percentage.

Cumberland County has the largest percentage of seniors, followed by Annapolis, Quens, Digby, Yarmouth and Guysborough counties. As might be expected, Halifax County has the smallest percentage because it is an academic, government and military center and therefore attracts a disproportionate number of younger people either involved in academic pursuits, the labour force or in military occupations (see Table 6, Figure 4).

The number of widows aged 65 and over greatly exceeds the number of widowers. Whereas in 1981 there were 5,950 widowers in Nova Scotia or 14.7% of those aged 65 and over, there were 25,745 widows or almost half the female population aged 65 and over. The fact that women live considerably longer than

men, has a direct bearing on the kind of programs and services we develop for seniors (see Table 7, Figure 5).

As might be expected, old age security and pension programs have brought about a decrease in the number of males 65 years of age and over participating in the labour force. On the other hand, the preponderance of widows in this age group and the increasing involvement of women in the work force have held the percentage at a more constant level but with a slight increase. In short, many women 65 years of age and over are compelled to work in order to survive, whereas an increasing percentage of males are retiring from the work force because of improving financial security (see Table 8).

There has been some improvement in the expectation of life compared to 1930, obviously brought about largely by improved health services. A male aged 65 in 1930 had an average life expectancy just short of 13 more years. By 1979, that had increased to 13.83 years. The expectation of life for females improved over the period by more than four years. To be precise, the female percentage increase was approximately four times that of the male increase over the same period. At age 70, the male life expectancy improves over age 65 while the increase in the female expectation of life at age 70 is slightly less dramatic than at age 65 (see Table 9). We do not have the corresponding statistics for 1982 but one may assume a consistent and steady improvement.

There was a considerable shift in the Canadian population from the rural to the urban areas from 1871 to 1971. The statistics are not available as yet for 1982 (see Table 10). Slightly more than 18% of Canadians lived in towns and cities in 1871. Thus, 82% were rural dwellers living on farms or in rural areas. By 1971, one hundred years later, that situation was almost reversed: 76.1% living in the urban area, only 23.9% in rural communities.

A comparable shift from 8.3% in 1871 to 56.3% in 1971 took place in Nova Scotia but we had a large rural population to begin with and by 1971 we were still well below the Canadian average of population in urban areas (see Table 10). The Nova Scotia percentage is likely to be somewhat higher for 1981 but, if

previous increases are safe indicators, the Nova Scotia percentage of persons living in urban areas is not likely to exceed 60%.

Tables 11-14 contain statistics on pensions and pension payments in Nova Scotia and the other Provinces. They are useful in obtaining an overall view of federal government involvement on behalf of seniors and the magnitude of financial responsibility now accepted by government.

The significance of these statistics may be summarized as follows:

- All seniors are living longer but women aged 65 and over have a much, much longer expectation of life at ages 65 and 70 than men. Thus the number of very old female seniors, widowed and living alone, is increasing and likely will continue to increase.

- Because health needs increase dramatically with advancing years and because the number of the very old is increasing, the need for chronic care, nursing home and home care services will continue to increase.

- Home care is more difficult where seniors are isolated and where loneliness, security, transportation, home repairs and snow removal are key problems. This will continue to be so and the large number of seniors living in rural areas will add to the difficulties and costs of providing home care.

- Transportation needs for shopping, church attendance and health services are greater in the rural areas than in the urban areas. Nova Scotia's large rural population means that we will have greater needs for these services than would be the case if we had a predominantly urban population.

- Loneliness affects all seniors whether living in urban or in rural areas. Negative factors such as great distances, isolation and transportation problems, especially in winter, aggravate the problem.

DEMOGRAPHIC TABLES AND FIGURES

Figure 1
Percentage of Provincial Population 65 Years of Age and Over - 1981

Because of out-migration since the turn of the century, Nova Scotia, like the other Maritime Provinces has always had a disproportionately large population of seniors over 60 and 65 years of age. The national average for Canada is 9.7% so that Nova Scotia's 10.9% is well above the national average.

Source:
Statistics Canada, *1976 Census of Canada*. Catalogue No. 92-823, Table 11.

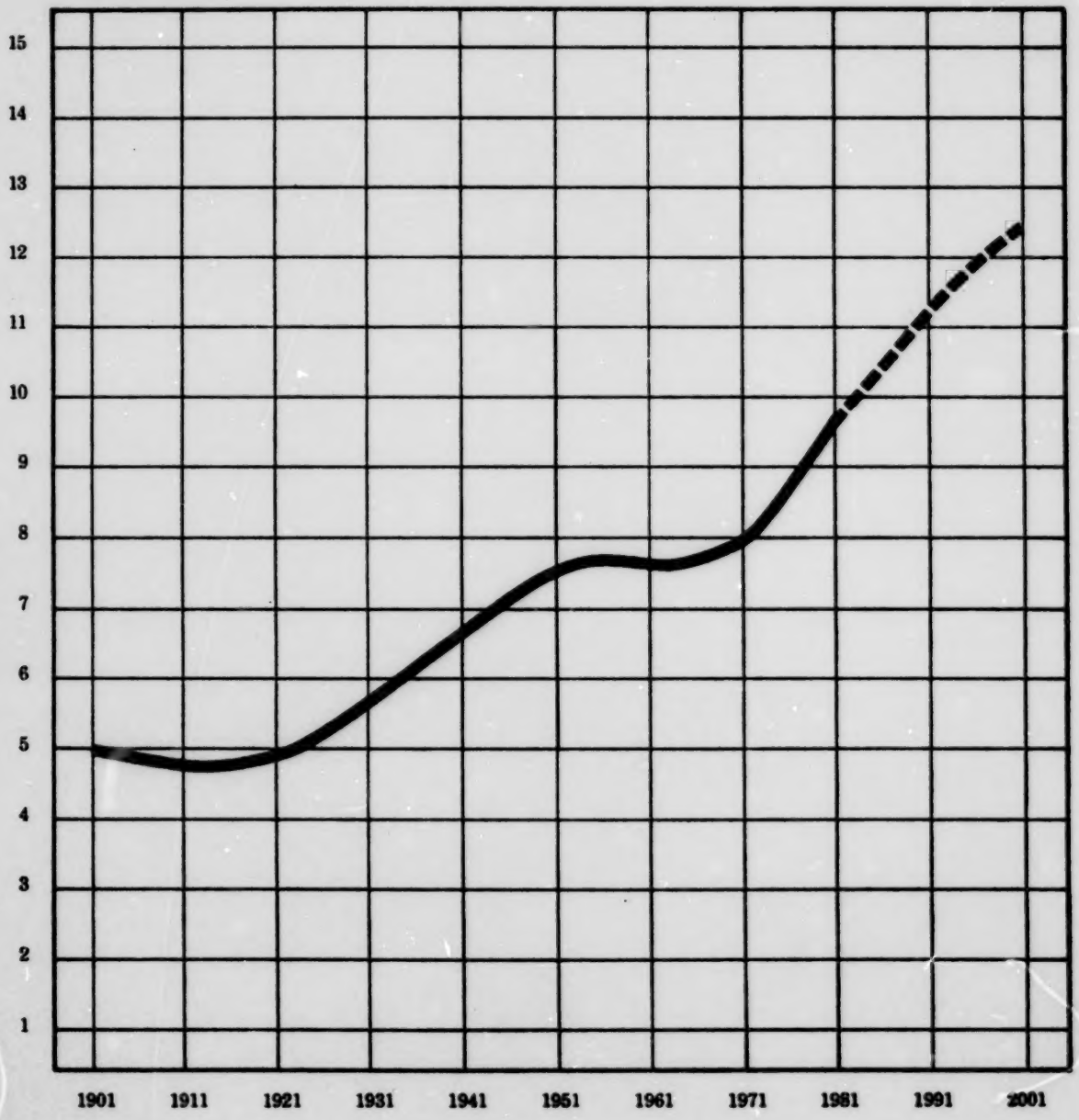
Table 1

POPULATION AGED 65 AND OVER AS A PERCENTAGE OF TOTAL POPULATION 1901-1981 WITH PROJECTIONS TO 2001, CANADA

YEAR	POPULATION (CANADA)	POPULATION 65+	PERCENTAGE
1901	5,371,315	271,201	5.0
1911	7,206,643	335,317	4.7
1921	8.787,949	420,244	4.8
1931	10,376,786	576,076	5.6
1941	11,506,655	767,815	6.7
1951	14,009,429	1,086,273	7.6
1956	16,080,791	1,243,938	7.7
1961	18,238,247	1,391,154	7.6
1966	20,014,880	1,539,548	7.7
1971	21,568,310	1,744,410	8.0
1976	22,992,605	2,002,345	8.7
1981	24,343,181	2,360,985	9.7
1986	25,160,000	2,588,300	10.3
1991	26,112,600	2,937,700	11.3
1996	26,813,400	3,189,100	11.9
2001	27,286,000	3,348,900	12.3

SOURCE: Statistics Canada, Census of Canada 1951, 1971, 1976, 1981 Population Projections for Canada and the Provinces 1976-1001. Projection 5.

Figure 2
Percentage of Population Aged 65 and Over in Canada
1901-1981 with Projections to 2001



Note: Broken line indicates forecasts from 1901-2001.

Sources:
Statistics Canada. *Census of Canada 1951, 1971, 1976, 1981 Population Projections for Canada and the Provinces, 1976-2001. Projection 5.*

Table 2

POPULATION OF NOVA SCOTIA AGED 65 AND OVER AS A PERCENTAGE OF TOTAL POPULATION 1901-1981 WITH PROJECTIONS TO 2001

YEAR	POPULATION	POPULATION 65 & OVER	PERCENTAGE
1901	459,574	31,000	6.0
1911	492,338	36,000	7.0
1921	523,837	38,000	7.0
1931	512,846	41,000	8.0
1941	577,962	47,000	8.0
1951	642,584	55,000	8.5
1956	694,717	59,000	8.5
1961	737,007	63,000	8.5
1966	756,039	67,000	8.5
1971	788,960	72,000	9.1
1976	828,571	81,000	9.8
1981	847,442	92,560	10.9
1986	878,600	98,100	11.2
1991	898,100	104,100	11.6
1996	911,000	106,100	11.6
2001	917,000	106,900	11.6

SOURCES: Statistics Canada, 1971 Population Census of Canada, Statistics Canada, Population Projections for Canada and the Provinces 1976-2001. Catalogue #91-520, Projection 5.

TABLE 3

CANADIAN POPULATION BY SPECIFIED AGE GROUPS
CENSUS YEARS 1871-1981 AS PERCENTAGE OF POPULATION 21 AND OVER

YEAR	45-64	65-69	70+	65+
1871	24.6	3.4	4.1	7.5
1881	24.1	3.4	5.3	8.7
1891*	*	*	*	*
1901*	*	*	*	*
1911	25.3	3.3	5.1	8.4
1921	27.4	3.6	5.1	8.9
1931	29.6	3.9	5.9	9.8
1941	30.7	4.4	6.6	11.0
1951	37.0	5.1	7.7	12.8
1961	30.6	4.7	8.7	13.4
1971	31.0	4.7	8.6	13.3
1981	48.9	8.9	15.9	24.8

*Breakdowns in 1891 and 1901 census are by five-year age groups only.

SOURCE: Statistics Canada, Census reports of various years.

Figure 3
Percentage of Population Aged 65 and Over in Nova Scotia
1901-1981 with Projections to 2001

Note: Broken line indicates forecasts from 1901-2001.

Sources:
Statistics Canada. *-1971 Population Census of Canada - Population Projections for Canada and the Provinces 1976-2001. Catalogue No. 91-520, Projection 5.*

TABLE 4

CANADIAN POPULATION BY SPECIFIED AGE GROUPS CENSUS YEARS 1871-1981 AS PERCENTAGE OF TOTAL POPULATION

YEAR	45-64	65-69	70+	65+
1871	11.1	1.5	2.1	3.6
1881	12.2	1.6	2.5	4.1
1891	12.9	1.8	2.8	4.6
1901	13.9	2.0	3.1	5.1
1911	14.1	1.8	2.8	4.6
1921	15.0	2.0	2.8	4.8
1931	16.8	2.2	3.3	5.5
1941	18.5	2.7	4.0	6.7
1951	17.7	3.1	4.7	7.8
1961	17.4	2.7	4.9	7.7
1971	18.6	2.9	5.2	8.1
1981	19.1	3.5	6.2	9.7

SOURCE: Statistics Canada Census reports of various years.

TABLE 5

POPULATION 70 AND OVER AS PERCENTAGE OF TOTAL POPULATION, CANADA AND PROVINCES, CENSUS YEARS 1901-1981

	1901	1911	1921	1931	1941	1951	1961	1971	1981
CANADA	3.1	2.8	2.8	3.3	4.0	4.7	4.9	5.2	6.2
NEWFOUNDLAND	--	--	--	--	--	4.0	3.8	3.9	4.8
PRINCE EDWARD ISLAND	4.3	5.3	6.0	6.5	6.3	6.5	7.0	7.8	8.0
NOVA SCOTIA	4.2	4.7	4.7	5.1	5.2	5.5	5.7	6.1	7.0
NEW BRUNSWICK	3.5	3.8	3.9	4.2	4.4	4.8	5.1	5.7	6.6
QUEBEC	2.9	2.8	2.7	2.9	3.1	3.4	3.6	4.1	5.6
ONTARIO	3.4	3.5	3.5	4.1	4.9	5.3	5.3	5.4	6.5
MANITOBA	1.3	1.4	1.7	2.6	3.6	4.9	6.0	6.4	7.8
SASKATCHEWAN	1.5	0.9	1.2	1.9	2.9	4.6	6.2	6.9	7.9
ALBERTA	0.9	0.8	1.2	1.9	2.9	4.0	6.4	4.7	4.7
BRITISH COLUMBIA	1.3	1.2	1.8	3.0	4.7	6.3	7.1	6.3	6.9

SOURCES: Statistics Canada, 1961 Census of Canada, Bull. 7.1-4, General Review: Age and Sex Composition, Table 3.
1971 Census of Canada, Special Bulletin, Catalogue No. 92-772.
1981 Census of Canada, Catalogue No. 92-901.

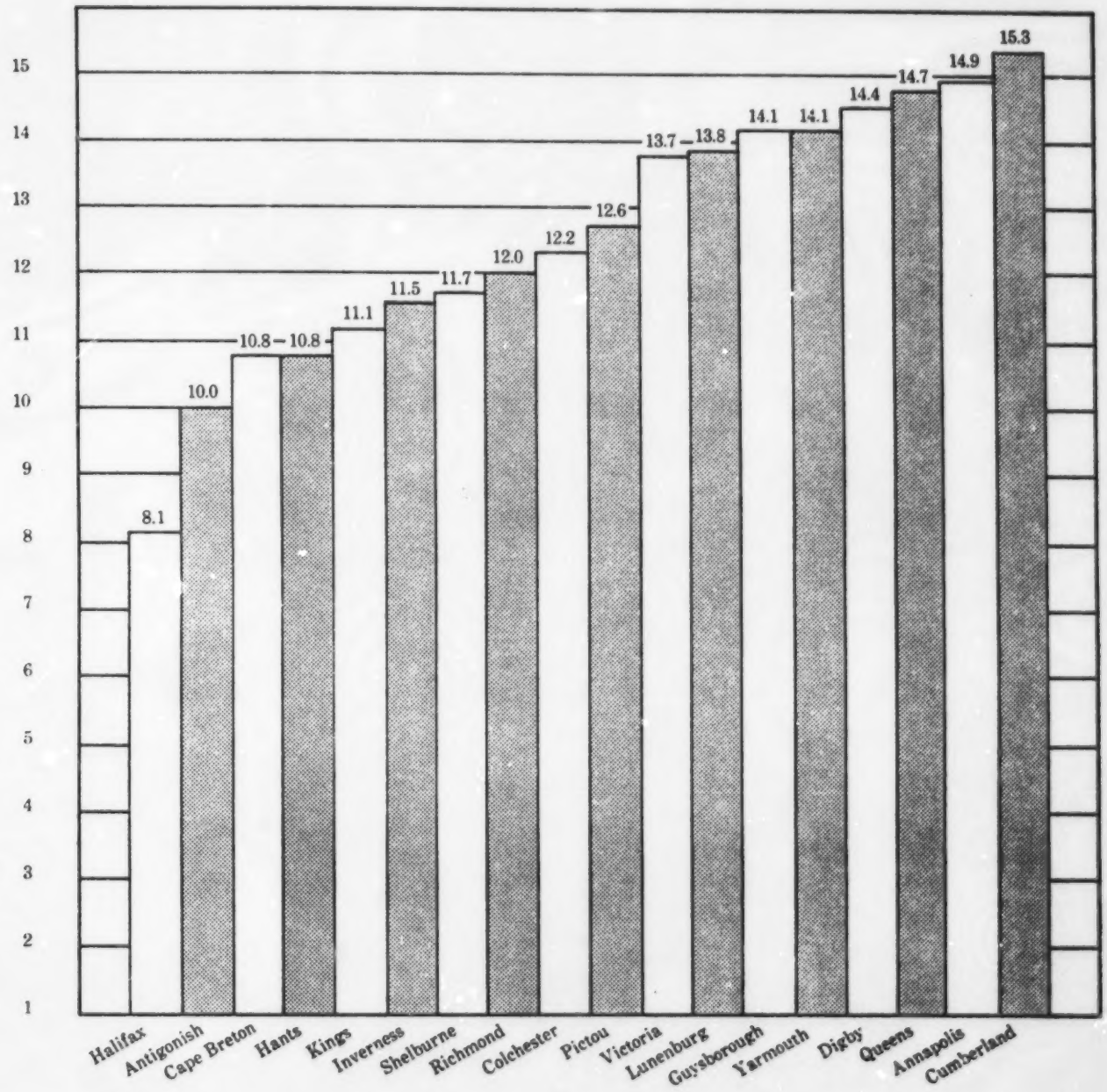
TABLE 6

POPULATION BY COUNTY AGED 65 AND OVER AS A PERCENTAGE OF TOTAL POPULATION, 1981 NOVA SCOTIA

COUNTY	TOTAL POPULATION	POPULATION 65 & OVER	PERCENTAGE
ANNAPOLIS	22,522	3,345	14.9
CUMBERLAND	35,231	5,405	15.3
INVERNESS	22,337	2,565	11.5
RICHMOND	12,284	1,480	12.0
ANTIGONISH	18,110	1,815	10.0
DIGBY	21,689	3,115	14.4
KINGS	49,739	5,520	11.1
SHELBURNE	17,328	2,030	11.7
CAPE BRETON	127,035	13,720	10.8
GUYSBOROUGH	12,752	1,800	14.1
LUNENBURG	45,746	6,320	13.8
VICTORIA	8,432	1,155	13.7
COLCHESTER	43,224	5,280	12.2
HALIFAX	288,126	23,450	8.1
PICTOU	50,350	6,345	12.6
YARMOUTH	26,290	3,715	14.1
HANTS	33,121	3,570	10.8
QUEENS	13,126	1,930	14.7
TOTAL - Nova Scotia	847,442	92,560	10.9

SOURCE: Statistics Canada, 1981 Census of Canada - Nova Scotia.

Figure 4
Percentage of Population Aged 65 and Over by County,
Nova Scotia 1981



Source:
Statistics Canada. *1981 Census of Canada - Nova Scotia.*

TABLE 7

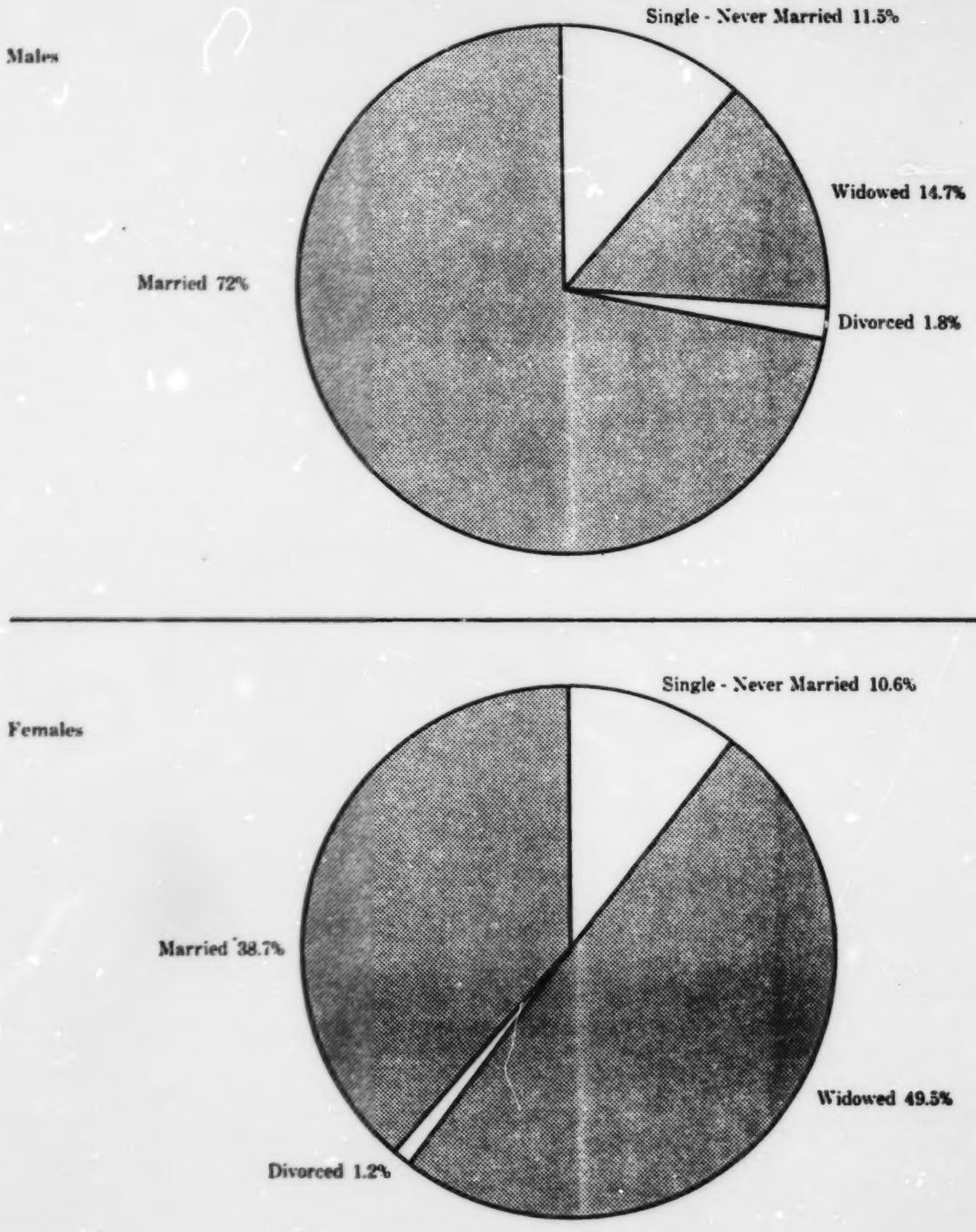
MARITAL STATUS OF PEOPLE 65 AND OVER
NOVA SCOTIA 1981*

MARITIAL STATUS	MALE		FEMALE		TOTAL
Single (never married)	4,645	(11.5)	5,485	(10.6)	10,130
Married	29,190	(72.0)	20,130	(38.7)	49,320
Widowed	5,950	(14.7)	25,745	(49.5)	31,695
Divorced	720	(1.8)	650	(1.2)	1,360
TOTAL	40,505	(100.0)	52,000	(100.0)	92,505

*Percentages given in brackets following figures.

SOURCE: Statistics Canada, 1981 Population Census of Canada, Age, Sex and Maritial Status, Catalogue No. 92,901.

Figure 5
Maritial Status of Males and Females 65 and Over, Nova Scotia 1981



Source:
Statistics Canada. *1981 Population Census of Canada. Age, Sex and Marital Status.*
Catalogue No. 92-901.

TABLE 8

MALE AND FEMALE POPULATION 65 AND OVER PARTICIPATING IN LABOUR FORCE, CANADA 1911-1981*

	MALES			FEMALES		
YEAR	TOTAL	PARTICIPATING		TOTAL	PARTICIPATING	
1911	170,613	28,103	(16.0)	164,704	3,566	(2.0)
1921	214,964	125,167	(58.0)	205,280	12,738	(6.0)
1931	294,550	163,787	(55.6)	281,526	17,449	(6.2)
1941	390,909	184,578	(47.2)	376,906	20,781	(5.5)
1951	551,303	212,399	(38.5)	534,970	27,188	(5.0)
1961	674,117	191,851	(28.5)	717,037	48,078	(6.7)
1971	781,865	184,700	(23.6)	962,540	79,355	(8.2)
1981		145,000			61,000	

* Percentages of males and females participating given in brackets following figures.

SOURCES: Statistics Canada, Eighth Census of Canada 1941 Volume 1.
Historical Statistics of Canada H.C. Urguhart, ed.
Toronto: MacMillan Company of Canada, Ltd.
Statistics Canada, Census of Canada 1961 Labour Force:
Occupation 1971 Census of Canada, Catalogue No. 94-704, Vol. III,
Labour Force and Individual Income.

TABLE 9

EXPECTATION OF LIFE AT SELECTED AGES, CANADA 1930-32 to 1975-79

	AT 20 YEARS		AT 45 YEARS		AT 65 YEARS		AT 70 YEARS	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
1930-32	49.05	49.76	27.79	28.87	12.98	13.72	10.06	10.63
1940-42	49.57	51.76	27.60	29.67	12.81	14.08	9.94	10.93
1950-52	50.76	54.71	28.05	31.14	13.31	14.97	10.41	11.62
1955-57	51.19	55.80	28.28	32.09	13.36	15.60	10.51	12.17
1960-62	51.51	56.65	28.49	32.82	13.53	16.07	10.06	12.58
1965-67	51.50	57.37	28.55	33.51	13.63	16.71	10.83	13.14
1975-79	51.74	58.81	28.85	34.90	13.83	17.90	11.12	14.33

SOURCES: DBS, Life Expectancy Trends, 1930-32 to 1960-62 (Ottawa: Queen's Printer 1967)
Life Tables, Canada and Provinces, 1965-67 (Ottawa: Information Canada, 1971)
Statistics Canada, Life Expectancy Tables, Catalogue No. 98-516.

TABLE 10

URBAN POPULATION AS PERCENTAGE OF TOTAL POPULATION, CANADA AND PROVINCES

CENSUS YEARS 1871-1971

	1871	1881	1891	1901	1911	1921	1931	1941	1951	1961	1971
Canada	18.3	23.3	29.8	34.9	41.8	47.4	52.5	55.7	62.4	69.7	76.1
Newfoundland	--	--	--	--	--	--	--	--	43.3	50.7	57.2
Prince Edward Island	9.4	10.5	13.1	14.5	16.0	18.8	19.5	22.1	25.1	32.4	38.3
Nova Scotia	8.3	14.7	19.4	27.7	36.7	44.8	46.6	52.0	54.5	54.3	56.7
New Brunswick	17.6	17.6	19.9	23.1	26.7	35.2	35.4	38.7	42.8	46.5	56.9
Quebec	19.9	23.8	28.6	36.1	44.5	51.8	59.5	61.2	66.8	74.3	80.6
Ontario	20.6	27.1	35.0	40.3	49.5	58.8	63.1	67.5	72.5	77.3	82.4
Manitoba	--	14.9	23.3	24.9	39.3	41.5	45.2	45.7	56.0	63.9	69.5
Saskatchewan	--	--	--	6.1	16.1	16.8	20.3	21.3	30.4	43.0	53.0
Alberta	--	--	--	16.2	29.4	30.7	31.8	31.9	47.6	63.3	73.5
British Columbia	9.0	18.3	42.6	46.4	50.9	50.9	62.3	64.0	68.6	72.6	75.7

SOURCE: Leroy O. Stone, Urban Development in Canada: An Introduction to the Demographic Aspects, 1961 Census Monograph (Ottawa: Queen's Printer, 1967), Table 2.2, p. 29.
Statistics Canada, 1971 Census.

TABLE 11

PENSIONERS IN PAY AND MONTHLY PAYMENTS, MARCH, 1982

PROVINCE	NO. OF PENSIONERS IN PAY	MONTHLY PAYMENTS
NEWFOUNDLAND	44,745	$ 17,590,451
PRINCE EDWARD ISLAND	14,959	5,699,706
NOVA SCOTIA	93,927	32,495,647
NEW BRUNSWICK	71,838	25,359,810
QUEBEC	576,957	198,428,856
ONTARIO	866,275	258,354,419
MANITOBA	122,796	39,140,405
SASKATCHEWAN	117,414	37,539,922
ALBERTA	161,334	51,390,454
BRITISH COLUMBIA	294,898	89,410,227
YUKON	718	253,365
NORTHWEST TERRITORIES	1,264	543,788
INTERNATIONAL OPERATIONS	1,454	292,003
NATIONAL	2,368,569	$756,399,053

* Includes Spouse's Allowance Payments

SOURCE: Health and Welfare Canada, Old Age Security. Report for the year ending March 31, 1982

TABLE 12

OLD AGE SECURITY PAYMENTS
FISCAL YEARS ENDING MARCH 1976-1982

PROVINCE	1976-1977	1977-1978	1978-1979	1979-1980	1980-1981	1981-1982
NEWFOUNDLAND	$ 98,062,334	$ 108,013,278	$ 122,923,841	$ 143,729,599	$ 170,937,506	$ 199,587,020
PRINCE EDWARD ISLAND	32,793,154	35,700,738	40,232,882	46,015,434	53,726,062	61,587,020
NOVA SCOTIA	191,973,474	209,064,846	235,779,105	271,375,206	320,249,984	370,871,266
NEW BRUNSWICK	147,372,906	160,784,587	181,536,704	209,361,299	247,417,167	287,381,130
QUEBEC	1,134,177,650	1,245,334,881	1,402,428,497	1,625,605,557	1,927,193,424	2,246,070,565
ONTARIO	1,535,638,666	1,687,188,467	1,913,760,969	2,191,470,831	2,548,146,230	2,940,625,969
MANITOBA	239,904,310	261,353,326	292,585,107	333,369,790	388,279,414	445,196,672
SASKATCHEWAN	229,524,914	249,602,489	279,182,273	318,958,664	370,454,516	426,705,610
ALBERTA	306,133,169	333,640,931	375,792,751	429,944,077	502,279,911	578,441,006
BRITISH COLUMBIA	516,719,843	565,633,367	641,404,120	743,081,791	879,799,475	1,017,090,310
YUKON	1,398,336	1,561,564	1,758,466	2,062,160	2,370,971	2,748,590
NORTHWEST TERRITORIES	2,974,630	3,301,494	3,690,669	4,254,482	4,928,975	5,906,857
INTERNATIONAL OPERATIONS	--	--	--	368,162	2,020,778	3,034,051
NATIONAL	4,436,673,386	4,861,179,968	5,491,075,384	6,319,597,052	7,417,805,413	8,585,309,808

SOURCE: Health and Welfare Canada, Old Age Security. Report for the year ending March 31, 1982

TABLE 8

RECIPIENTS UNDER THE OLD AGE SECURITY PROGRAM BY TYPE OF BENEFIT AND PROVINCE, MARCH 1982

PROVINCE	TOTAL OAS RECIPIENTS	GUARANTEED INCOME SUPPLEMENT RECIPIENTS				TOTAL SPOUSES ALLOWANCE RECIPIENTS
		RECEIVING MAXIMUM BENEFITS	RECEIVING PARTIAL BENEFITS	TOTAL RECIPIENTS	PERCENTAGE RECEIVING GIS BENEFITS	
NEWFOUNDLAND	44,745	17,265	18,987	36,252	81.02	3,526
PRINCE EDWARD ISLAND	14,959	3,280	7,480	10,760	71.93	745
NOVA SCOTIA	93,927	19,118	42,962	62,080	66.09	4,778
NEW BRUNSWICK	71,838	16,166	31,684	47,850	66.61	3,893
QUEBEC	576,947	121,445	246,064	367,509	63.70	27,343
ONTARIO	866,275	78,641	305,981	384,622	44.40	23,922
MANITOBA	122,796	14,475	51,682	66,157	53.88	4,445
SASKATCHEWAN	117,414	15,400	46,171	61,571	52.44	4.334
ALBERTA	161,334	21,196	61,145	82,341	51.04	5,517
BRITISH COLUMBIA	294,898	32,142	103,553	135,695	46.01	8,527
YUKON	718	207	151	358	49.86	17
NORTHWEST TERRITORIES	1,264	776	212	988	78.16	43
INTERNATIONAL OPERATIONS	1,454	140	490	630	43.33	13
NATIONAL	2,368,569	340,351	916,562	1,256,813	53.06	87,103

SOURCE: Health and Welfare Canada, Old Age Security. Report for the year ending March 31, 1982.

TABLE 14

PROPORTION OF GIS RECIPIENTS AMONG PEOPLE 65 AND OVER

BY SEX AND AGE, CANADA AND PROVINCES JUNE 1979

PROVINCE	MALE	65-69	70-74	75+	FEMALE	65-69	70-74	75+
NEWFOUNDLAND	78.8	70.4	81.2	87.9	81.7	73.5	81.4	89.6
PRINCE EDWARD ISLAND	71.2	57.7	72.4	82.4	73.8	62.8	72.5	81.8
NOVA SCOTIA	62.2	52.0	64.0	72.8	66.6	56.7	65.0	75.7
NEW BRUNSWICK	63.6	52.9	64.6	74.5	67.5	56.1	66.2	77.6
QUEBEC	58.9	50.0	60.3	69.3	65.7	55.6	66.0	75.2
ONTARIO	38.5	27.3	39.0	51.4	47.3	32.9	45.1	59.9
MANITOBA	50.4	36.0	50.2	65.1	58.0	42.6	55.8	71.4
SASKATCHEWAN	48.1	33.0	48.0	62.2	56.9	43.3	56.7	67.8
ALBERTA	48.0	33.0	48.7	62.6	54.8	41.3	54.6	66.5
BRITISH COLUMBIA	43.4	30.5	42.9	57.6	50.1	36.9	47.6	62.6
CANADA	48.5	37.3	49.2	61.0	55.8	43.3	54.6	67.0

SOURCE: Statistics Canada, Old Age Security, Guaranteed Income Supplement and Spouse's Allowance, 1982.

REFERENCES

1. Special Senate Committee on Retirement Age Policies. Retirement Without Tears. (Hull, Quebec: Minister of Supplies and Services, 1979)

2. Ibid. p. 42-43.

3 Canadian Fundamental Report on Aging. (Ottawa: Department of National Health and Welfare, 1982) p. 1

4. Op.Cit., p. 2-3.

5. Op. Cit., p. 3.

6. Victor W. Marshall, Aging in Canada - Social Perspectives. (Don Mills: Fitzhenry and Whiteside Limited, 1980) p. 20.

CHAPTER FOUR

PROVINCIAL GOVERNMENT PROGRAMS AND SERVICES

HEALTH PROGRAMS

The Department of Health operates in five main areas of interest and professional responsibility.

Community Health Services

Community Health Services include nursing, nutrition and dental services, health education, epidemiology and child health. In respect to seniors, the key areas of concern are community nursing, which provides extensive home nursing services, and the nutrition service.

Community health nurses provide health promotion, health education and nursing care to the elderly as part of the general community health nursing services offered by the Department of Health.

Home visits are made to the elderly primarily to help them remain in their homes and to promote their health and mobility. The community health nurses assess their health status, determine if they are under medical supervision, comply with medical orders, provide medication counselling as necessary and foot care.

The nursing staff may also assist the well elderly with bathing in the tub. The community health nurse does nutrition counselling with the elderly and helps them to adjust the preparation and storage of food from family to single portions.

In some areas of the province, well elderly clinics are held. At these clinics the community health nurse provides each elderly person who attends

with assessment and approriate counselling. If necessary, the nurse refers the person to the agency that is best able to help in solving his or her problem.

The nurse may plan to have other health professionals such as the community health nutritionist or dental hygienist attend the well elderly clinics to assist with special problems. Health educational materials are provided at these clinics. If time permits, films and slides on a health topic are shown.

Most of the senior citizens' housing units are visited by the community health nurse. The same services that are provided during home visits are offered to the residents.

Community health nurses may be contacted directly by an elderly person or by the family, the physician, staff of an agency or even a neighbour on the client's behalf. Many of the elderly clients on the nurse's caseload are found when visits are made for other reasons to homes in the community.

The services provided by the community health nursing staff are free of charge to the clients, regardless of age. Therefore, the elderly receive service at no direct cost.

Environmental Health

The Department has, for many years, emphasized the importance of environmental health. This requires linkages with the provincial Department of Labour, the Workers' Compensataion Board, the Department of Mines, universities concerned with the teaching of occupational health, and other federal-provincial bodies concerned with environmental hygiene.

Hospital Services

The third area of responsibility concerns hospitals which provide acute and chronic care.

Mental Health Services

The Mental Health Services division provides direction for mental hospitals and psychiatric services.

The Health Services and Insurance Program

The Health Services and Insurance Commission is responsible for the direction of:

- physician's services
- surgical-dental services in hospitals
- vision analysis by optometrists
- drug programs for residents 65 years of age and over
- dental services for children born on or after January 1, 1967, or for students registered with the School for the Blind. The services terminate at the end of the month during which the student reaches the age of 16 years
- program for sufferers of cystic fibrosis
- dental program for patients with cleft lip-cleft palate
- drug program for those suffering from diabetes insipidus related to the pituitary gland and
- a program of drugs for cancer patients.

The plans are designed to provide all eligible residents of Nova Scotia with a broad range of coverage. Maritime Medical Care, a private corporation, has been assigned the responsibility of administering these programs for the Commission.

The Pharmacare plan is available to all residents of Nova Scotia who have been registered under the M.S.I. program and are 65 years of age and over. Pharmacare covers those preparations dispensed by a pharmacist which are normally prescribed by a doctor or dentist in the course of treatment.

All people eligible for Pharmacare are provided with a personalized plastic "pharmacard" which is presented to the pharmacy with the prescription.

If the pharmacy agrees to participate under the plan, a claim form is completed listing the medication(s) and cost. The claim is signed by the senior or a designated representative of the senior acknowledging receipt of the dispensed prescription(s). The pharmacist gives the senior a copy of the claim and sends one to M.S.I., which pays the pharmacy directly.

If the pharmacy does not participate in the program, the senior will be advised, immediately, by the pharmacist on presentation of the Pharmacard; in such a case, the senior is required to pay for the prescriptions dispensed. The non-participating pharmacy then gives a "Pay Patient" claim form to the senior, properly completed. The completed form is sent to M.S.I. and payment is made directly to the senior, up to the amount that would be paid a participating pharmacy for dispensing the same prescription.

If there is no pharmacy within 15 miles of the physician's office, provision is made to ensure drugs are provided by the physician. Provision has also been made for nursing homes, extended care facilities and similar institutions to be granted "authorized provider" status by M.S.I. for the dispensing of insured prescription services.

Basic health services including hospitalization and medicare have, since their inception in the sixties, been provided on a universal basis, available to everyone without a test of income or need and without fee. The Provincial Government and the Department of Health are firmly committed to this principle of universality.

There has been much discussion about balance billing, sometimes referred to as extra billing, in respect to medical services. There are those who hold that balance billing, regardless of magnitude, is in the long run injurious to a universal medical service plan. Proposals have been made from time to time that balance billing be prohibited by statute; the federal government is now threatening to

resort to penalties if balance billing is permitted. Seniors are heavy consumers of health services, particularly physician services, so the issue of balance billing is of considerable importance to them. In Nova Scotia, in 1970, only 3.2% of the cost of physician services came from balance billing; by the first three months of 1982 the percentage had dropped to 3.1. We are informed by the medical profession that in the case of seniors, physicians have been requested to exercise care to insure that there is no balance billing when such might put a burden on the patient. The Department of Health takes the position that balance billing is a non-issue partly because the statistics show it is not being abused and partly because the Department believes it is a significant factor in the climate of good relations that prevails in Nova Scotia between the government and the medical profession.

There is no formal program of chronic care for the elderly; however, acute care hospital beds are being used for chronic care, especially in hospitals where there is a surplus of beds. A number of patients requiring chronic or extended hospital care are also in nursing homes. This condition exists because the health of guests in a nursing home may deteriorate over the years. The nursing home program has now been in operation for 18 years. Guests in nursing homes who require chronic care have no other place to go; this accounts for the growing number of chronic care patients in the nursing home system. Extended or chronic care patients in acute care hospitals are not required to pay for hospitalization since it is provided under the Hospital Insurance and Diagnostic Services Act. Nursing home guests requiring chronic care are expected to pay for their care and if they are unable to do so the municipal level of government becomes responsible; the costs are shared by the province and the federal government. Some provinces provide chronic or extended care as an insured service under the Hospital Insurance Plan.

A broad spectrum of health services will be required if home care is to be truly effective and if it is to be a practical alternative to institutional care. Nursing care provided through the community health program is the most obvious. Occupational therapists, physiotherapists, speech therapists and other

specialists in the field of health care will also be needed as a home care program develops and matures.

A central issue in health care will be the ability of federal and provincial governments to maintain and extend health services. Gross costs are increasing at a rate not anticipated in the sixties when the services were initiated. It is doubtful if these costs have peaked nor are they likely to peak in the immediate future. It is becoming increasingly evident that there is limited possibility of economic growth and therefore revenue growth, comparable to what we experienced in the sixties and seventies. A major expansion of health services to seniors will therefore be difficult or impossible to achieve in the immediate future. At the same time, new services such as home care and chronic care are needed by the senior population. Other programs such as geriatric day care are also required if we are to make any substantial headway in shifting the emphasis from institutional to home care.

Social reformers often find it difficult to understand why new and essential programs should be delayed. Frustrated, they may charge government and those involved in government administration with short-sightedness and unwillingness to change from the status quo. They see the alternatives as costing less in the long run and therefore question why implementation is being delayed. Government, however, is committed to programs that are largely irreversible. Few, if any, existing programs can be eliminated and this, along with the fact that existing financial resources are strained to the limit explains the inability of government departments to take on new responsibilities that would require substantial financial outlay no matter how excellent and cost-effective they may seem to be.

SOCIAL SERVICES PROGRAMS

Special Social Assistance

The province began paying Special Social Assistance to seniors in the spring of 1973, in response to a marked increase in the cost of living - especially the cost

of energy. The gross payment made to 45,563 seniors in the first year of operation amounted to $4,573,315 with the federal government cost-sharing these payments in the amount of $1,429,100.

There was considerable debate as to whether the payments should be universal to all seniors or selective, and if selective, what kind of resource test should be used to determine eligibility. It was finally decided to limit the payments to recipients of the Guaranteed Income Supplement because in that way a provincial determination of eligibility would be unnecessary. The payment was directly related to the amount of G.I.S. paid by the federal government based on the assumption that the greater the G.I.S. payment the greater the degree of financial need. The fact that the province did not apply a needs test of its own accounted for the small amount of federal cost-sharing. This decreased even further in the second year of the plan's operation when a total pay-out of $4,782,580 brought only $713,124 in federal cost-sharing.

The present government attached a cost of living factor to the payment in 1979 and in 1981 the payments were authorized by legislative enactment (Chapter 11 of the Statutes of Nova Scotia, 1981).

Senior citizens are eligible for Special Social Assistance if they are receiving the Guaranteed Income Supplement to the Old Age Security pension on March 31 of the year of application and are living in Nova Scotia at the time of application. If both members of a couple are receiving the Guaranteed Income Supplement, both qualify for the Special Social Assistance payment. There are four levels of payment directly related to the amount of G.I.S. received by the senior citizen and in inverse proportion. The 1983 payments were $109, $146, $197, and $219. Federal cost-sharing is insignificant.

Application forms are automatically mailed out to all senior citizens who receive the Guaranteed Income Supplement.

Property Tax Rebate

The Property Tax Rebate program was introduced in the fall of 1980 and provides for a rebate of 50% of the net municipal residential property tax for the preceding year.

Senior citizens who are receiving the Guaranteed Income Supplement to the Old Age Security pension or the Spouse's Allowance, who own their own home for which the rebate is claimed, and who regularly reside in that home, are eligible.

For the fiscal year ending March 31, 1983 there were 18,852 recipients of this assistance for a total cost of $2,603,924; the average payment per recipient was $138. There has been no federal cost-sharing for this particular program so that the entire payment is made from the provincial budget.

The application forms are automatically mailed to senior citizens who are eligible for the rebate. The tax bill and tax receipt showing that the taxes were paid in full must be attached to the application form.

Rental Assistance

Rental assistance, introduced in the spring of 1981, provides for a monthly subsidy to be paid to eligible senior citizens who rent self-contained living accommodation in the private market. Senior citizens who rent in the private market, who are not living in subsidized public housing or homes for special care, who are receiving the Guaranteed Income Supplement to the Old Age Security pension or Spouse's Allowance or who are single with an income below $9,800 and who are paying rent that exceeds 30% of their income, are eligible. The amount of assistance granted depends on the senior citizen's income and the amount of rent paid subject to a ceiling for single and married individuals. The following tables indicate the amount of the assistance payment.

TABLE 15

Amount of Rental Subsidies
For A Single Person*

INCOME PER MONTH	MONTHLY RENT								
	$120	$130	$140	$150	$160	$170	$180	$190	$200 and over
$395	15	15	16	24	31	39	46	54	61
410	0	15	15	19	25	33	40	47	54
425	0	15	15	16	23	30	37	44	51
440	0	15	15	15	20	27	34	41	48
455	0	0	15	15	16	23	30	37	44
470	0	0	15	15	15	19	25	32	38
485	0	0	0	15	15	16	22	29	35
500	0	0	0	0	15	15	20	26	33
515	0	0	0	0	15	15	17	24	30
530	0	0	0	0	15	15	15	20	27
545	0	0	0	0	0	15	15	17	24
560	0	0	0	0	0	15	15	15	21
575	0	0	0	0	0	0	15	15	18
590	0	0	0	0	0	0	15	15	15
605	0	0	0	0	0	0	0	15	15
620	0	0	0	0	0	0	0	15	15
635	0	0	0	0	0	0	0	0	15
650	0	0	0	0	0	0	0	0	15

* The income levels are shown on the left hand side and the monthly rent at the top of the table. The subsidy is determined at the point where the income and rental lines meet.

TABLE 16

Amount of Rental Subsidies for a Couple

For the fiscal year ending March 31, 1983 an average of 1,651 people received this assistance for a total cost of $940,000. In August, 1983 there were 1,660 recipients for a total cost of $82,437 with an average monthly payment per recipient of $49.66. There has been no federal cost-sharing for this particular program; the entire payment is made from the provincial budget.

Homes for Special Care

Homes for Special Care include residential facilities that provide supervisory, personal and/or nursing care for disabled and older citizens who find themselves unable, even with community support systems, to remain in their own homes and neighbourhoods.

Three types of Homes for Special Care are available to senior citizens:

- Homes for the aged are operated either by municipal governments or private, non-profit organizations. They provide supervisory or personal care to individuals 65 years of age and older. Sometimes there are nursing sections in these homes for the aged, providing nursing care for seniors requiring it.

- Nursing homes are privately operated and provide supervisory, personal and nursing care to residents requiring these services on a 24-hour basis. The admission age is somewhat flexible. There is a lack of specialized facilities for young, physically disabled people. Individuals such as the victims of traffic accidents, for example, are therefore cared for in nursing homes. The average age of the nursing home population is 82 years. The average age of guests in homes for the aged is 88. The discrepancy is due to the considerable number of younger disabled persons being cared for in nursing homes which, of course, lowers the average.

- Residential Care Facilities are small, privately operated facilities that provide supervisory and personal care to residents. These are sometimes referred to as licensed boarding homes.

The department licenses all Homes for Special Care, regularly inspects the homes, and requires compliance with health, fire, program and staffing standards. Under the provisions of the Homes for Special Care Act, boarding homes caring for three or fewer than three guests need not be licensed. It follows that there are a very large number of boarding homes, particularly in the rural areas, caring for one, two or three senior guests of which the Department has no knowledge and for which there are no registration or licensing requirements.

Individuals who are able to pay the full or partial daily cost of their care are required to do so. For people who receive the Old Age Security or Spouse's Allowance, a part of the cost is covered through this payment. However, approximately 70% of all guests in homes for the aged and nursing homes have insufficient financial resources to fully provide for their maintenance so that some assistance is required.

The responsibility for determining eligibility for social assistance in a Home for Special Care rests with the government of the municipal unit where the person resides and has applied for admission. The municipal unit may or may not accept the applicant, depending upon its policies. If the applicant is accepted, the Department of Social Services is consulted and then determines the level of care suitable for the applicant. A Home for Special Care is then selected and a placement is made by the municipal body to which the application is addressed. The municipal unit provides one-third of the cost of care not provided for through a combination of the applicant's resources and Old Age Security. The remaining two-thirds is covered by the province. Prior to 1978 the federal government assumed 50% of the cost of government supported guests in Homes for Special Care. In 1977 the federal financial responsibility was defined in the Established Programs Financing Legislation (EPF). The actual cost-sharing percentage ranged from a high of 61% in 1977-78 to the present 49%. Forecasts indicate that the percentage will drop still further in the next few years.

The costs of care for a guest in a Home for Special Care are calculated on a daily rate basis and vary from home to home depending on the level of care provided and the facility's approved operating budget.

The province is served by a network of 118 special care homes caring in all for approximately 5,000 seniors. These break down into 22 nursing homes, caring for 1,643 guests, and 35 homes for the aged, caring for 3,369 guests. In addition there are 61 boarding homes caring for approximately 1,000 guests of which about half are seniors.

There are two formulae in use to determine whether a province or region has sufficient beds for its senior population. The first formula requires the number of beds available to be equal to or greater than 5% of the population 65 years of age and over. As of June 1, 1982 there were 92,560 persons 65 years of age and over; by this yardstick, we should have 4,628 beds available. There are as noted, 5,000 beds available and approximately 500 additional boarding home beds. Thus, even allowing for the fact that the formula refers to the population 65 years of age and over, while the available beds are being used by people aged 60 and over, there appear to be sufficient beds available.

The second formula requires that we have 4.5 beds per 1,000 of population. The Nova Scotia population as of June 1, 1979 was estimated to be 847,442. This formula would require us to have 3,184 beds for seniors of all ages; obviously, Nova Scotia is well above the maximum which that formula yields.

As of January 1, 1983 there were 184 additional new beds forecast to come into use that year.

In addition to the homes for the aged, nursing homes and residential care facilities, the province subsidizes nine Adult Residential Centres and four Regional Rehabilitation Centres. As of January 1, 1983, out of a population of 835 persons in Adult Residential Centres, 192 were 65 years of age and over. In the Regional Rehabilitation Centres, out of a population of 381, 65 were 65 years

of age and over. Thus 257 or 21% of the 1,216 patients in these facilities were in the senior citizen category.

The rehabilitation centres provide for physically and mentally disabled adults. The population is made up primarily of two categories of individuals:

- ex-mental patients who cannot live on their own in the community and who require institutional care

- individuals who, because of mental or physical disability, are unable to get along on their own in the community and require institutional care.

The immediate issue relates to where these elderly patients should be cared for. Many of them know no other home except the rehabilitation centre where they are being housed. Would it be advisable or humane to transfer them when they become elderly to a facility for seniors? Should separate provision be made for the 257 seniors now being cared for in rehabilitation centres?

Family Benefits

A Family Benefit is monthly financial assistance paid to individuals and families by the Province of Nova Scotia where there is financial need and where the cause of the need is likely to be prolonged.

A few senior citizens are ineligible for Old Age Security and may apply for Family Benefits. Eligibility is determined by a needs test which takes into account the applicant's income and expenses. A number of seniors aged 65 and over are heads of families in which there are children under 16 years of age.

If disabled within the meaning of the Family Benefits Act, these individuals may be eligible for Family Benefits. The monthly payments are adjusted upwards twice yearly with the cost of living index, and the amount of the monthly payment is determined by a needs test.

The Family Benefits Act also provides for the payment of benefits to unemployable women 60 years of age and over to age 65. On March 31, 1983, 78 women in this category were receiving an average monthly payment of $253.38; for the year ending March 31, 1983, $243,151.00 was paid to this group.

The federal government cost-shares 50% of all Family Benefits paid by the province.

Municipal Social Assistance

Municipal Social Assistance is available to seniors who experience need and who require some degree of supplementation of such income support programs as Old Age Security and private pensions. There are 67 municipal units in the province and each unit has its own rules and procedures for the payment of short-term assistance. Eligibility depends on financial needs, and programs such as Old Age Security and Family Benefits may be supplemented by the municipal unit depending upon local policies. The amount of assistance paid is related to the income and resources of the individual applicant. Responsibility for the management and administration of municipal assistance rests entirely with the municipal unit. Each unit develops its own policies which must be approved by the Minister.

In the early years of the Municipal Social Assistance program, the Foundation Scale was used to determine the financial responsibility of the municipal unit, which in no case is greater than 25%. The remaining costs are paid by the province with the federal government cost-sharing 50% of the overall expenditure. The Foundation Scale is no longer in use, but the cost-sharing percentages set by that scale are being continued.

Homemakers

A homemaker service was initiated in Nova Scotia in October, 1978. During the current fiscal year it is estimated that the gross provincial expenditure on this item will amount to $1,875,500. This amount represents 75-93% of the costs of

the service. The remaining costs are provided by the local community. The services provided by the Department of Social Services at the moment include housekeeping, preparing meals, budgeting and personal hygiene and grooming. The current homemakers program is provided by municipal government, Children's Aid Societies, Family and Children's Services or private and non-profit agencies. There are no provincial agencies directly involved in providing homemakers services.

Any citizen may apply for homemakers services and individual applicants may be referred by a physician, social worker, hospital, friends or other agencies. The agency then decides if it can meet the needs of the applicant. The entire province is served by homemakers agencies.

The cost of providing homemakers services is calculated by the homemaker services agency on an hourly rate basis and ranges from the minimum wage of $3.75 to as much as $7.00 an hour depending on the location, the standards maintained by the agency, and other factors.

There is a standard income test that meets the requirement of the federal government so that all expenditures made within the rules and regulations set by the federal government are eligible for 50% cost-sharing. The program is available to any local community on the condition that the community, either through private subsidy or the municipal level of government, provides the initial 25% of the cost.

Clients not eligible for subsidization through the application of the income test and federal cost-sharing, are expected to pay the full hourly rate. The application is made directly to the Homemakers Service Agency serving the community in which the applicant resides.

HOUSING PROGRAMS

A description of the Department of Housing's programs relevant to senior citizens follows. Current issues that have implications for future housing

programs are considered. The need for ongoing public information and interagency program coordination is noted. The continuing need for affordable rental housing, as provided by the senior citizens' housing program, and the need to expand the options of affordable rental housing beyond current programs are discussed. The use of public housing in conjunction with an existing special care facility, to provide independent housing with ongoing access to additional services, is one example of the types of new approaches and applications that are being considered in order to provide the needed range of housing services.

Assistance to homeowners in maintaining adequate accommodation through home repair and needed renovations is also an ongoing program need. The approaches from other jurisdictions, the use of volunteer services, and the recommendations and comments of senior citizens will play an important part in assessing existing programs and in developing new approaches and options.

Senior Citizens' Public Housing

The Department of Housing, Canada Mortgage and Housing Corporation, and the relevant housing authority in the municipalities, work together to provide affordable, comfortable living accommodations for senior citizens. The apartment units are self-contained bachelor or one-bedroom suites. Some units are designed for handicapped seniors.

The administration and management of these units rests with the local housing authority, of which there are 45 in Nova Scotia. The admission process is the responsibility of the local housing authority.

An applicant, in order to be eligible for admission, must be 58 years of age or older and must be physically and mentally capable of self-care in an apartment. There is a 12 month provincial residence requirement during the three years immediately prior to the application. There is no income ceiling but priority is given to applicants in the lower income group.

The rent, of course, is subsidized by both the federal and provincial governments. The tenant pays 16.7 - 25% of his or her gross income in rental. The capital and operating costs are shared 75% by CMHC and 25% by the Department of Housing. The provincial share of the operating cost is divided between the province and the relevant municipality.

Some 5,550 units of senior citizens housing have been constructed and are available in the province through the local housing authority.

Non-Profit Housing

The Department of Housing, Canada Mortgage and Housing Corporation, public and non-profit housing groups, and relevant municipalities work together to provide non-profit housing.

The purpose is to provide housing to low and moderate income groups, and to individuals requiring special care due to physical or mental infirmities.

Those eligible are:

- public non-profit groups organized to represent and made up of provincial or municipal representatives (members of municipal councils, etc.) and working through the Department of Housing;

- private non-profit groups comprised of members drawn from church organizations, legion branches, etc., and who deal directly with Canada Mortgage and Housing Corporation.

Canada Mortgage and Housing Corporation insures a loan to the non-profit housing group through a private lender. Canada Mortgage and Housing Corporation provides a subsidy, if required, in the form of a write-down on the interest rate of the loan from the current rate to 2%. Should the write-down not provide sufficient assistance in public non-profit projects, the Province of Nova Scotia will share in the operating loss, dollar for dollar, with the municipality until the provincial share reaches a maximum of 12.5% of the operating deficit

or 25% of the federal contribution, whichever is less. Any additional deficit must be covered by the municipality.

Rents paid by tenants are similar to those paid under other provincial Public Housing Programs.

The public non-profit group, after having been incorporated, advises the Department of Housing of the project it wishes to undertake. Such projects may be new construction or the acquisition and conversion of existing units. The group must also indicate the "all in" costs of the project, the estimated revenue from rentals, and the cost of operation.

Private non-profit groups deal directly with Canada Mortgage and Housing Corporation.

Senior Citizens Assistance Program

The Department of housing provides this program, the purpose of which is to assist senior citizens wishing to remain in their own homes but who cannot afford to carry out the necessary repairs.

The eligibility requirements for the client are:

- the individual or spouse must be 65 years of age or over,
- must have a combined annual income of $12,000 or less,
- must own, be part owner or have a life interest in and must reside in the dwelling for which the application was made and
- must not have received previous assistance.

The eligibility requirements for the dwelling are:

- must be principal residence of applicant,
- must be single family unit and
- may be detached, semi-detached, one unit of row housing or a mobile home.

The form of assistance is forgiveable loans of up to $3,000. The loans are secured by a Loan Agreement. Loans are forgiven at the rate of $50 per month as long as the recipient continues to own and occupy the premises. If title is transferred, the unforgiven balance becomes due and payable.

Provincial Housing Emergency Repair Program

The Department of Housing is solely responsible for this program, the purpose of which is to provide assistance to people with low incomes who cannot afford to carry out the emergency repairs required to ensure the preservation of their home as a habitable unit.

The eligibility requirements for the client are:

- the client must own, be part owner or have a life interest in the dwelling for which the application is made and must occupy the dwelling,
- only housing posing severe health and safety hazards will be considered for this program.

The eligibility requirements for the dwelling are:

- the dwelling must be the principal residence of the applicant, and
- it must be a single family unit,
- may be detached, semi-detached, a mobile home or one unit of row housing.

A one-time grant of up to $2,500 is made for labour and materials.

Access-a-Home

The Department of Housing uses the Access-a-Home program to assist individuals or family members whose mobility is limited to wheelchairs.

To be eligible, the applicant or a member of the applicant's family must be limited to a wheelchair because of a long-term disability and must own, be a part-owner, or have a life interest in and reside in the dwelling for which application is made. The dwelling must be the principal residence of the

applicant. It must be a single family unit and may be detached or semi-detached, a mobile home or one unit of row housing used as a home.

The work that may be done must relate to those architectural barriers which restrict the use of a wheelchair; the result of the work must be of a permanent nature.

Applicants with a gross family income of $15,000 or less may receive a grant of 90% of the first $1,500 of the approved work and material up to a maximum of $1,350. If the gross family income is between $15,000 and $30,000 the grant may be 70% of the first $1,500 of approved work and material in place. Beyond that, a maximum grant of $750 applies.

Applications for all of these programs and services are made to the Regional office serving the Department of Housing. There are four regional offices in all, located in Sydney, New Glasgow, Bedford and Middleton.

In this century, Canadians have moved from a rural society, with an occasional small town or village, to become urban dwellers congregated in large centres of population, living in rented accommodation, very often high-rise apartments. The transition has been more gradual in Nova Scotia but even here the change has had far reaching implications. At the turn of the century, most seniors lived in the rural areas. Houses were large and commodious even if they were poorly heated and uncomfortable. At least housing, such as it was, was plentiful and relatively inexpensive. Conveniences were few and hardships were many but home ownership created a degree of independence which was characteristic of that time. With the advent of paved highways, consolidated schools, improved transportation and communication, young people left the farms and the rural areas to find work in the growing centres of population where industrial development was concentrated. Gradually, the seniors who remained died off, leaving the farms to grow up in spruce trees.

Large areas of northern and eastern Nova Scotia were suitable only for subsistence farming. The outcome was inevitable as the industrial age progressed and employment opportunities became available elsewhere in Nova Scotia and in other parts of Canada.

Increasingly, the advantages of urban living appealed to seniors and more and more to young people. The costs of materials, labour and land have skyrocketed in the past half century. Thus, the entrepreneur is forced to charge high prices for housing, and market rents are reaching levels out-of-reach of the average senior. Owning a home has become expensive even if the costs are largely hidden. Renting brings the total costs out on the table in plain view. The squeeze between income and shelter costs is becoming increasingly tight.

The Delivery of Housing Services

The great diversity of housing needs and the different levels of services required by the aging and the aged have resulted in housing services being delivered by a wide variety of public and private agencies. The result has become a complex system of many housing programs and services involving a wide range of delivery agencies and systems.

Two important activities can maximize the benefits and minimize the costs of housing services, now and in the future, while avoiding the difficult, time-consuming and expensive task of entirely revamping the delivery system. First, an information program about housing services is required at the community level. The information would outline available services, eligibility criteria, user cost and provide a contact for program information. Provision of information at the community level will allow for adjustments according to community differences and local contacts. Second, coordination and information exchanges between delivery agencies are necessary to avoid potential duplications and ensure that the needed services are provided efficiently.

The issue of who delivers housing services and how they are delivered will continue to grow in importance. Government services and programs reflect the

tremendous social policy changes that have occurred over the last 20 years. With these changes, the views of the electorate have also changed from almost a "laissez-faire" approach to an apparent attitude that "government" should look after all. Government policies will not result in a return to the "laissez-faire", however government restraint is forcing a re-evaluation of current programs and services, and will restrict new major government initiatives. Government restraint may prove to be a positive factor, helping to create increased cooperation, improved self-help and low technology solutions to housing issues. However, until alternative approaches are implemented, constraint will be a factor in the delivery of housing services.

Volunteers now play an important role in the delivery of services that help seniors to maintain an independent lifestyle. The effective delivery of housing services in the future should not only rely on the public and private agencies, but also on volunteers and senior citizens themselves.

The "how" of housing services delivery is closely tied to who delivers the services. Rather than consider the best approach to program delivery, which will vary, there are certain overriding issues that should be addressed by the delivery systems. The delivery systems and services should offer a range of choices for housing services and provide the flexibility and information that allows participants to select the services best suited to their needs. As previously noted, information and coordination provided at the community level are important factors in providing an effective delivery system.

Program delivery and development will be key factors in effectively meeting the current and future housing needs of the aged and aging. Consultation, particularly with senior citizens who are using the services, should become an ongoing process to ensure that the housing and housing services provided best meet the clients' needs. Faced with constraint and increasing need for housing services, new approaches for housing services will have to be considered. This will involve experimentation through pilot projects, and some risk. A Nova Scotian pilot project has successfully provided senior citizens rental housing in conjunction with a special care facility. This housing has met

the need for some on-going services for those who otherwise are able to live independently, and it has provided a less-costly alternative to special care housing. Foster homes and day care are options that have been successfully implemented in other Canadian communities. These options provide senior citizens with the flexibility to increase and, more significantly, to decrease the level of service they receive, based on their needs. Cooperative housing and shared accommodation based on the approach of Great Britain's Abbeyfield Society, which matches compatible senior citizen roommates with senior citizen homeowners, are other options that could be considered in providing a range and diversity of housing services to meet the current and future senior citizens needs.

Housing Affordability

The previous section reviewed some of the key issues in the delivery of housing services, but it did not consider the issues that create the need for senior citizens' housing services. Housing affordability and adequacy are the basis of the housing problems facing the aging and aged. The issues of housing affordability are inseparably tied to housing costs and income. Many of these issues overlap with the issue of housing adequacy.

Traditionally, senior citizens households which rent their accommodation and single-person households, particularly single women, face the greatest housing affordability problems. Almost 90% of Nova Scotia's senior citizens are in independent households and almost 80% (approximately 45,000 households) own their own homes and approximately 11,000 households rent their homes. Approximately 55% of the renting households are single women and 33% of the homeowners are women in single-person households. Approximately 7,500 of the senior citizens who rent their accommodation either receive the provincial rent supplement or live in publicly-owned rent-geared-to-income apartments. However, demand for rent-geared-to-income apartments for senior citizens far exceeds supply; for example, in Metropolitan Halifax alone as of September, 1982, there were over 600 applications for senior citizens' housing and in

Industrial Cape Breton there were over 800 applicants for senior citizens' housing.

Two options are available to senior citizens trying to obtain affordable, rental housing: the rental assistance program and the publicly-owned rent-geared-to-income program. As the rent for private market units increases and the supply of rental housing remains limited, senior citizens seeking rental accommodation are faced with growing affordability problems. Without significant increases in rent supplements, it is unlikely that the current programs can offset the increasing costs. Other forms of income supplement would require major government expenditures. Publicly-owned rental housing provides affordable rental housing throughout the province. Although the program should continue to provide affordable housing, rising subsidy costs and capital funding restrictions, in addition to the long-term nature of the program, require other options be considered in conjunction with the programs currently offered.

Homeowners have traditionally been considered to be in a better position when housing affordability is considered and are not faced with mortgage payments. The senior citizen homeowner, it is argued, has a major capital asset in the form of a home, which is not used to offset affordability problems. To date, attempts at introducing reversed mortgage schemes to other parts of Canada have not been successful. The income from the sale of a home in many cases may not be sufficient to pay rental housing, given the rising rental costs and the low vacancy rates. Many senior citizens who are homeowners live in rural areas where there may be a limited market for the sale of a residential property. Thus, any proposal that relies on the senior citizen's home for a source of capital will have to consider whether the proposal meets the long-term needs of homeowners facing affordability problems.

Municipal property taxes, maintenance, and energy costs are key issues for homeowners facing housing affordability problems. Nova Scotia now provides senior citizens with a property tax rebate which helps to offset rising property taxes. A major proportion of the housing owned by senior citizens is older, and therefore may have higher energy and maintenance costs.

The province, through the Senior Citizens' Assistance Program, has provided funding to senior citizen homeowners who are unable to afford necessary home repairs. Grants and loans to upgrade energy efficiency of existing housing have also been available to homeowners through federal and provincial programs.

Maintenance and energy costs will continue to be major forces in housing affordability. Government programs have been one approach used to offset major capital expenditures. The issue of ongoing maintenance requirements and their cost is also an important area where utilization of volunteers and approaches other than public programs could be considered. All programs and services developed to offset the affordability problems of homeowners will have to consider whether the housing provided remains appropriate and thus adequate to the homeowner and the cost of combined special services required to maintain the homeowner in his or her house, given the other available program options and their costs.

Housing Adequacy

Adequate housing for the aging and the aged, as for anyone, should at least include affordable housing that meets health and safety standards and provides the residents with the required housing services; while maximizing their independence. The wide range of services and the different levels of service required to meet the needs of the aging and the aged raise two of the major issues of housing adequacy. First, future housing services will have to be diverse to provide senior citizens with the range of choice needed to meet their needs. Secondly, senior citizens will have to have the flexibility and information necessary to select the housing services best suited to their requirements. Flexibility should be extended to allow senior citizens to increase and decrease the housing services they receive, based on their needs.

Housing adequacy is inseparably tied to a wide variety of other services available to senior citizens. Housing may or may not be adequate given the availability (and cost) of needed health and social services. For example, a

senior citizen may be able to live independently in an apartment if homemaking services are available on a regular basis. The need for a range of services and their inter-relationships reflect the need for coordination and information outlined in the discussion of program delivery.

When housing adequacy is considered independently, the ability of homeowners to maintain their homes is often mentioned. Not only do they require sufficient funding for the work required, they also must be able physically to undertake the continuous maintenance needs or have ongoing assistance for regularly required home maintenance. For some senior citizens, homeownership of a large, single detached home designed for a family, with its rising costs and ongoing maintenance responsibilities, may not offer the greatest independence, physically or financially, particularly as they become older. Apartments or other housing forms may provide the senior citizen with more adequate accommodation and greater independence.

Housing adequacy for the aging and the aged goes beyond the physical condition of the structure. Although housing condition is an important factor, health care, social services and the independence provided are also major issues in the provision of adequate housing.

EDUCATIONAL, CULTURAL AND RECREATIONAL PROGRAMS

Education

Responsibility for programs related to aging and the aged lies with the Continuing Education Branch of the Department of Education and that division is taking an active role in working with senior citizens. Continuing education recognizes the important function played by senior citizens in the structure of both the family unit and the community. Special provision for senior citizens groups has been made in a number of existing programs.

The continuing Education Branch:

- has designated a staff member to be responsible for developing and coordinating programs for senior citizens
- supports a wide range of classes for adults through local school boards. These classes are specifically designed for senior citizens and may be arranged by contacting the local school board
- assists in organizing senior citizen clubs, associations, and councils
- provides continuing education facilities and resource materials
- sponsors and assists in organization of leadership seminars
- develops and presents preretirement and retirement seminars
- supports and assists school boards in organizing community schools. Community school programs and activities are designed to meet the recreational and vocational needs of all age groups in the community
- provides consultative services and minimal funds for projects designed to improve the quality of life of senior citizens throughout the province
- provides advice, counselling, and consultation through six regional offices of the Department of Education.

Recreational Services

Local recreational programs are available throughout Nova Scotia offered by municipalities, community groups and organizations. They are provided through the assistance of the provincial Department of Culture, Recreation and Fitness.

Programs for senior citizens include recreational and cultural activities, fitness and exercise classes.

The Department of Culture, Recreation and Fitness makes information on local problems, activities, interest groups and workshops available to senior citizens and encourages the senior community to become more involved in all facets of recreation.

As a catalyst in motivating individuals and organizations as well as other government departments and agencies to expand recreational opportunities for

senior citizens, the Department of Culture, Recreation and Fitness has established six regional offices in strategic locations throughout Nova Scotia. A regional representative has been appointed to supervise department of cultural, recreation, sport and fitness activities in the area.

These regional representatives advise interested individuals, groups, associations and municipal units on how to utilize the funding offered them for recreational programs with the ultimate aim of giving all Nova Scotians equal opportunities for recreational involvement.

Outdoor recreation, sport facility development and community recreation are a few of the services offered by the department to the municipalities and local groups fulfilling the current recreational needs of senior citizens.

As one of its many responsibilities, the Department of Culture, Recreation and Fitness, through its regional offices, helps community organizations to make improvements to existing buildings for use as community centres through the Little Red Schoolhouse Program and the RFD Program.

The improved facility should have other opportunities for public usage thereby assisting a variety of activities relating to recreation, sport and culture.

The Regional Fitness Development Program financially assists interested individuals or community organizations to develop fitness programs, to host fitness conferences and/or workshops, and to provide financial aid to encourage and promote attendance at fitness conferences and seminars given by fitness leaders.

Application for this assistance is open to any senior citizens' group or individual wishing to initiate one of these programs.

In the cultural area, the department initiated the Senior Citizens' Drama Club as one of its pilot projects, and is willing to assist in the development of

theatre companies and workshop programs for senior citizens in all performing arts areas.

Community service groups and municipal authorities may apply on behalf of senior citizens' organizations, if one of their main objectives is the provision of social, recreational and cultural services for senior citizens.

Universities

Senior citizens may attend universities in Nova Scotia without paying tuition. All that is required is proof that the senior is 65 years of age or older.

Mount Saint Vincent University also offers a certificate in Gerontology. This program is intended for professionals such as nurses, social workers, physicians and administrators who are currently working in the field of aging and who wish to become more effective in their work by broadening their understanding of aging. Those professionals who do not have at least one year of university study may be accepted in the certificate program if they can demonstrate that they have an experiential and/or training equivalent to such study. Undergraduate students who are interested in gerontology may enroll in the courses, providing they meet all requirements for those courses. However, such students will not be permitted to enroll in the Certificate in Gerontology program unless this program is an adjunct to a degree program.

Elderhostelling

Elderhostelling is a program for individuals over 60 and combines the best traditions of education and hostelling. It has been inspired by the Youth Hostels and Folk Schools of Europe and generally provides one-week experiences of campus life and academic stimulation. The program is designed to answer the need of older citizens for intellectual growth and it appeals to seniors who are mobile and capable of reaching out to new experiences. It is based on the belief that retirement should not mean withdrawal and that one's senior years should

provide opportunities for learning and growth. The atmosphere is such that making new friends is easy and learning can be exciting and stimulating.

The program is especially appealing to couples although it need not be thus restricted.

On campus the hostellers may choose from a number of courses in the Liberal Arts and regular courses made available by the university in question. There are no examinations, no grades and no required homework although professors may make suggestions for outside reading. Lack of formal education is not a barrier to admission or learning so that whether the senior is a Ph.D. or a grade school drop-out, the experience may be equally beneficial.

Most universities offer Elderhostellers a variety of extra-curricular activities, however, these are expensive and have to be limited accordingly.

Elderhostellers live in the rooms of the college dormitory chosen to be the hostel. Meals are eaten in the college cafeteria with other summer school students.

The cost of Elderhostelling is about $50 per person per week. Meals are over and above this basic cost. Tuition for a week's course runs about $150.

We are concerned here with a series of programs that differ greatly from health, social services and housing. Whereas all of these are viewed by the taxpayer as basic necessities, there continues to be a prevailing attitude that physical fitness, leisure time activities, cultural pursuits and the like are frills which may readily be postponed or dispensed with, especially in times of recession and tight budgets. For many Nova Scotians, these are relatively new programs which are not high priorities or necessities for our senior population.

The good physical and mental health of our senior population takes on increasing importance as the numbers of that age group increase. Preventive health programs such as those which promote good physical and mental health

mean that less money will be spent on physician's services and institutional care. The services provided through these two departments - Education and Culture, Recreation and Fitness - are of inestimable long-term value in promoting good physical and mental health and insuring the general happiness and well-being of seniors. A quick pay-off may not be clearly visible but it will accrue in sundry ways that may be difficult to calculate in terms of immediate savings.

The importance we assign to improved educational, recreational, cultural and fitness programs for our senior citizens is a fundamental measure of our real concern for our senior population and will continue to be a central issue confronting us.

A number of voluntary associations representing seniors contend that the school curriculum should contain information regarding aging, the significance of aging, and the relationships between youth and old age. As is the case of sex and religious educ[illegible] there are sharply differing views on this subject. For those opposed, the arguments are clear-cut. The school curriculum now contains a number of subjects which have been inserted over the last two or three decades because of public demand. There is a limit in respect to how far we can go in adding new subjects to the school curriculum without eventually neglecting or excluding the basics. This all leads to the question: should this information and these values be disseminated in the home, the church, and the community? What clearly belongs in the school curriculum? The advocates for including information in the school curriculum look at the increasing numbers of the old and the very old and the falling birth rate over the past decade or more. They are fearful that the imbalance of population will create intergenerational friction and they argue the way to head this off is to explain the developing situation to the current generation of school children. The question deserves our most thoughtful study.

There is every indication that unemployment will continue to be high in the next two decades because of automation and the increased use of computers in industry. These factors, of necessity, will produce a diminishing labour force. The dropping birth rate which we are now experiencing may have some positive

effect on this scenario but that is unlikely. Prolonged unemployment at the rate we are now experiencing will affect the retirement age and create pressures for early retirement. At the same time seniors are living longer and their capacity for productive involvement in the community increasing. What positive use will the community make of the growing number of seniors thus retired and not directly involved in the work force? Obviously, seniors can, and many very much wish to, make a useful contribution to voluntary community activities. How will seniors spend the increasing amont of leisure time available to them? Will we find ways and means of using their skills, knowledge and wisdom, or will it be wasted? Certainly the physical and mental health of our senior population will depend greatly on the creative thinking and the positive answers that we find for these questions, which are becoming more pressing each year.

CHAPTER FIVE

THE ROLE OF THE FAMILY, THE PRIVATE SECTOR, MUNICIPAL AND FEDERAL GOVERNMENTS, AND THE PROFESSIONAL

THE FAMILY

There is much worry in the Western World about the family. Falling birth rates, rising divorce rates, increasing numbers of working mothers and single parents, and alleged increases in juvenile crime all seem to point to a decline in family life.

It is not easy to find the proper instruments and rules to make the necessary measurements of the way things are now and the way they were at the beginning of this century or earlier. Without such measurements conclusions about the status of the family in today's society can be very misleading. Generally speaking, we view social change negatively so that there is a tendency for each new generation to look at the family and pronounce with doom and gloom that it is going to the dogs. We have to be sure our measurements are correct.

We have already made general reference to the subject of personal responsibility. It is emphasizing the obvious to observe that the family continues to be the primary learning centre where habits of personal responsibility are instilled and nurtured. However, families are dependent on parents who are individuals and who bring to parenting all the strengths and weaknesses to which human beings are prone. The role of the family is made even more difficult because outside influences, some negative and harmful, bear upon it and confuse even the best and wisest parents.

We use the world "familial" on occasion in this paper. A familial society is one in which caring and sharing is central and a way of life. In that sense we may have familial ties and relationships beyond our immediate family in the

world of work, leisure, church and school. In short, the positive features of family life are evident wherever there is an abundance of caring and sharing.

Personal responsibility and initiative grow out of a feeling of self-worth and a degree of conviction that life as it is with all its imperfections and ills is worthwhile and good. This conviction is nurtured in the familial setting from birth on and especially in the very early years of family life when love, compassion and understanding from parents or substitutes should be freely and abundantly given. In many situations the building is done so well that the fortress is well nigh impregnable to outside negative influences. There is no substitute for this early nurturing and there is no place except a familial setting where the strengths that flow from that nurturing may be developed.

Without that base and beginning the individual is ill-prepared to cope in today's society. Without self-confidence and self-worth, and a firm belief in the essential goodness of life, an individual is only a short step from feeling alienated, rejected, worthless, hostile and irresponsible. We have many examples of this in today's society.

We talk glibly about dependency, lack of initiative and individual irresponsibility. At times we blame government for fostering these qualities. In fact, we generally get the kind of community and the kind of government we deserve and if we truly want to encourage a society in which self-reliance, personal initiative and responsibility are significant values, then the place to begin is with families and children.

Children who have been shown a bad example by their parents and their elders, children who have been mentally and/or physically ignored, neglected and abused, can scarcely be counted on to have respect for old age. Worse still, they form a community of individuals who become alienated, irresponsible and lacking in initiative. Children who have experienced love, caring and compassion in their own family and who have learned from the example of community leaders who have shown caring and compassion are more likely to be strong and able to cope. More importantly, they will tend to perpetuate these qualities in their own

families, thus building a society in which self-reliance, personal responsibility and initiative are important values.

Mary Jo Bane has written a book Here to Stay on the subject of American families in the Twentieth Century.[1] There is no comparable statistical analysis or conclusions on the Canadian scene although the Vanier Institute of the Family is currently giving the matter attention. Ms. Bane concludes that marriage, child-rearing and family ties in the United States today provide solid, convincing evidence that family commitments are likely to persist in our society. She emphasizes that family ties are not remnants of tradition but rather a visible and persistent manifestation of the human need for stability, continuity and the special kind of love and affection found only in the family. If this is correct, and we believe it is , we cannot afford to ignore it in developing public policy.

The passage from childhood through adolescence to adulthood is very often a troubled and stormy transition characterized by the struggle to achieve what we have come to think of as independence. What produces the tension is the need to throw off the dependency of childhood and become a self-sustaining adult.

In old age, the cycle is reversed. As we live longer, become very old and often beset by chronic illness, we become dependent again even as we were dependent in early childhood. Thus, the human story runs full cycle from birth to old age.

But only in the very young and the very old is this dependency clear-cut. The truth is that for most of our lives we are interdependent, tied in countless ways to our fellow man and the familial setting in which we live.

What does family and being familial mean? Has the dependent senior any right to look for help, support and affection from adult children in the same way and to the same degree the children had a right to look for help, support and affection when they were making the no less difficult and painful transition to adulthood?

This is a central and basic question we need to face, though not for financial reasons although finances enter into the relationship. The issue is central for at least two reasons:

First, man is a social creature. Most of our pleasures and happiness arise out of relationships with others. It is a fact of life that loneliness is one of the major problems facing the aged. There is no sure way of guaranteeing a solution for this problem but the nurture of family, and the persistence of family ties, offer the most hope in the long run. Family loyalty treats people on the basis of special relationships. Family members generally make no pretence of treating strangers the same way they treat family.

Second, there is solid evidence that in our zeal over the past half century to improve social conditions we have in very important ways undermined the family. Public policies and public bodies can never replace parental care nor can the socially caring state ever fully meet the affectional needs of the old. Psychiatrists, psychologists, social workers, doctors, nurses and the institutions over which they preside very often weaken rather than strengthen family ties and family loyalties. If we develop public policies that undermine family life for the young, we are bound to reap a harvest of breakdown of attitudes when these same young persons reach old age. "As the twig is bent, so the tree grows." If we would like to have a society in which the old and the very old are loved and cared for by their families then we shall have to develop public policies and a society in which children grow up with these values solidly implanted in them.

THE PRIVATE SECTOR

Terms such as private sector and non-governmental sector are used interchangeably to mean the same thing. In this paper, private sector means that network of human resource agencies concerned with aging and the aged which is managed by a Board or Committee of citizens not answerable or responsible for the management and oversight of its affairs to any level of government. The agency may be, and often is, in receipt of some degree of funding from government but the funding would be provided without management

strings attached. That does not preclude the proviso that such funding may have to be used for a specific purpose. If the funding is contingent upon the organization disbursing it according to specified government rules and regulations then it is not a purely voluntary or non-governmental agency. To use a modern alphabetical description it becomes a QUANGO, a quasi, non-governmental organization. There are few if any QUANGOs in Nova Scotia in this field of aging and the aged, although the VON might well fall in that category if it should become extensively involved in providing home nursing care as a part of an overall provincial home care program.

A major issue is the role the private health and welfare agency will be permitted to play in cooperating with government to provide services to the aged and aging. The Victorian Order of Nurses is a private health agency providing a community nursing service. The Department of Health also has a community nursing program. If a provincial Home Care program is developed, what use will be made of the VON?

A relatively new philosophy has emerged in the last two decades concerning the role of government, the public perception of government's role, and the role of the private sector. The media has contributed, and continues to foster these perceptions. Basically, government is on one side epitomized as entrenched authority. Most often it is described as bureaucratic and its personnel as bureaucrats, using the term in the perjorative sense. In this morality play, government is described as "they". "We" are the public cast against "them", government, the adversary. This adversarial system often places the private sector and the non-governmental agency in the role of Sir Galahad.

It would be grossly unfair to say that this perception is universally held. Indeed, there are those who would argue that the adversarial system we have unwittingly created often works the other way with the private sector cast as the villain of the morality play.

The point to be emphasized here is that there should be no place for the adversarial system in public-private relationships. We cannot afford the luxury of sniping at each other nor do we have the resources that would justify the waste of energy, money and time that flows from this lack of cooperation.

The central issue is not one of activism on the part of the voluntary agency, nor is it one of creating an adversarial system of good guys and bad guys. In reality, it comes down to making the wisest and the most efficient use of scarce resources. The essential issue then is how to achieve and maintain cooperation between the public and private sector.

MUNICIPAL GOVERNMENT

Historically, during the 18th and 19th Centuries, all social services were provided by local government or voluntary agencies, the latter, for the most part, under the auspices of the Church. The most important of these municipally administered services was financed and managed at the parish level. The Elizabethan system of caring for the poor through financial levies on the parish was brought to Nova Scotia shortly after Cornwallis founded Halifax in 1749 and it continued to be the accepted method of public provision for the needy until 1958 when it was replaced by more modern social assistance legislation.

From the middle of the 19th Century, there was a gradual erosion of municipal responsiblity for the poor. This culminated in 1958 in a system that provided a series of federal income maintenance programs for certain groups of needy persons and provincial social assistance legislation for the residue who might be ineligible for any form of federal aid or whose assistance from the federal government required supplementation.

In 1958, legislation did not abolish municipal responsibility. It provided for provincial cost-sharing, leaving the basic administrative and managerial responsibility for residual assistance with the municipal level of government. That system, designed in 1958, has continued up to the present time.

Health took quite a different direction. Municipal boards of Health have negligible responsibility in respect to seniors' programs. They may, for example, become involved in the suitability of sites and locations for housing units and Homes for Special Care but even in these areas the Provincial Public Health Inspector has overriding authority.

The central and primary responsibility for the maintenance of public health rests not with the municipal level of government but with the province. Universally available medicare and hospitalization are the central pieces in that provincial responsibility. Whereas health services are universally available through the provincial Department of Health, social services with some exceptions, both provincial and municipal, are available only on a needs or income test basis; this is the distinguishing factor in respect to programs provided by the two departments.

FEDERAL GOVERNMENT

The British North America Act of 1867 was enacted at a time when health and welfare services were of minor significance to Canadians. Even the terms "social services and social welfare" did not exist in the language of the day. Responsibility for charitable institutions was therefore assigned to the provinces and municipal government, for the most part a creation of the provinces, assumed the administrative responsibility.

The First World War and the decade following it brought about a marked shift in population from rural areas and small villages to the larger urban centres. This was due largely to growth in industry, increased mobility and improved communications. All was well as long as the country was prosperous and jobs were plentiful. The depression of the thirties "brought the lesson home" to all political parties that the system of caring for the sick, the poor and the unemployed enshrined in the British North American Act of 1867 was outdated and wholly unsuited for Canada in the 20th Century.

Rapid change and federal involvement in health, welfare and housing programs characterized the period following the Second World War.

What are the major issues confronting Nova Scotia now as we plan services for seniors in cooperation with the federal government? What role would we envision for the federal government?

Old Age Security, Spouse's Allowance, the Guaranteed Income Supplement and New Horizons are programs which are wholly managed and financed by the federal government. They present no problem, therefore, in respect to relationships between the two levels of government.

Relationship problems arise primarily in the management of shared cost programs. When Old Age Pensions were introduced by the federal government in 1927, the political, social and economic structure of Canada was such that it was possible for a province to elect non-involvement in the federal program, at least for a time. Nova Scotia waited six years before enacting complementary Old Age Pension legislation and taking advantage of the federal cost-sharing. That might not be a politically or socially viable alternative for a provincial government in 1984 for the simple reason that a federal cost-sharing intervention in the social field would now create immediate pressures with respect to provincial involvement which would be difficult to resist.

The federal government now has the power to radically alter provincial priorities and spending with respect to social policy objectives if it decides to do so. In a time of expanding revenues and budget surpluses federally and provincially, such as we experienced in the sixties and early seventies, there was much merit in the concept of federal leadership in health, housing , and the social services. If Canadian citizenship means anything, certainly it should mean that services should be reasonably uniform from one part of Canada to another or, at least, that seniors living in Nova Scotia have access to a minimum level of services.

Federal cost-sharing, the resultant policy pressures which it placed upon the provinces, to provide improved services was therefore a laudable social policy. Certainly a senior moving from British Columbia, for example, to Nova Scotia in 1984 would not be faced with the same gross disparities in social programs that would have been evident in the thirties.

The equalization formula used to equalize services in the less wealthy provinces has never fully compensated Nova Scotia for those social and economic problems which up to now have negatively affected revenues and requirements for services. Cost-sharing has, therefore, been a socially and financially desirable feature of federal-provincial relations, at least for the Atlantic Provinces. If Nova Scotia were richly blessed with expanding revenues, one might well argue that federal cost-sharing is an undesirable social policy, creating as it does program priorities which may or may not be the precise priorities we would approve. The question is academic in our case.

Fortunately, the Canada Assistance Plan which provides 50% federal cost-sharing of social assistance, provincial and municipal, and as well of certain specified social services, has not been substantially changed since its enactment in 1965. The major exception is that federal cost-sharing of Homes for Special Care was included in the Established Program Financing (E.P.F.) formula in 1978. To date, this change has not altered the original 50% cost-sharing to any appreciable degree.

On the health side, the E.P.F. formula has posed problems due largely to changes in the agreement relating to federal financial responsibility.

The central issue in federal-provincial relationships, therefore, is the stability and dependability of federal cost-sharing initiatives and the resulting relationships with the province. The essential requirement for stable relationships is the long-term reliability of federal commitments in respect to cost-sharing agreements and other federal-provincial arrangements.

THE PROFESSIONAL

Comprehensive services for aging and the aged require the professional expertise and knowledge of several academic disciplines. Just as income maintenance and service programs involve several departments of government at the federal, provincial and municipal levels, developing the knowledge base underlying services to the elderly, likewise, requires an interdisciplinary approach.

Health professionals primarily involved in the care of the elderly are drawn from medicine, dentistry, pharmacy, optometry, nursing and related paraprofessional groups. In addition, several professional disciplines are involved from the social sciences. Cope Schwenger, writing in the first issue of the Canadian Journal on Aging on the subject "Professionalization of Health Care for the Aged"[2], refers to a series of problems relating primarily to status and relationships that are all too evident in the expanding health services field. These conflicts have a direct bearing on the effectiveness of the health services we will be able to develop for the elderly in the next decade. Costs are affected as well.

Schwenger has this to say about costs:

> ".... We have predicted that if we continue along the present path, institutional and physician expenditures on the elderly will double in 25 years and that shortly after the turn of the century, spending on these two major categories of health care will actually be greater than for all the rest of the population put together, this in spite of the fact that elderly as a proportion of the general population is projected to rise from 9% to 12% over almost the same period of time. This phenominal growth will be fed particularly by the institutional sector (to which access is gained in large part through the medical profession) and to a lesser degree by the costs of medical care itself which in Canada is provided under a national health insurance scheme (in contradistinction to the United States). Another major factor which we analyzed was the cost of prescription drugs which, in the Province of Ontario, are provided free to the elderly and for which allocation is again largely in the hands of the medical profession...."[3]

Referring to cost implications, Schwenger points out that it will be difficult to support the existing numbers of professional categories necessary to care for the elderly, especially the very old, and we will have to make much better use of our highly-qualified and expensive health professionals than we are now doing. He points out that Britain gets along wilth only a few hundred strategically placed geriatricians in teaching and service capacities.

It is an unfortunate fact that the productivity of professionals and paraprofessionals involved in providing services to seniors is seriously diminished by the interprofessional rivalries that exist between health professionals and social science professionals and also within the health professions where the rivalries are even more serious. Schwenger states that "competition between older and newer professionals has been, on the whole, destructive and by no stretch of the imagination could it be construed to be in the interest of the elderly".[4]

"Well being" is a phrase that may be used to describe a state of good health, mental and physical, a reasonable degree of financial security, adequate shelter and a settled and contented state of mind. To achieve "well being" for our elderly population, health services in the broadest sense must be available to the senior; health professionals must be knowledgeable about every aspect of aging. The involvement of health professionals goes much further than research and fact-finding in respect to disease entities. They must, for example, come to grips with such questions as; What is the purpose in prolonging life indefinitely if at the same time the quality of life diminishes to the point where, for many, the added years may be a liability? If the answer to that question leads to a conclusion that new approaches are needed, then that conclusion should not be ignored.

What will improvements in medical science do for the "well being" of the individual senior? When, for example, the average life span was 40 years and medical science reduced mortality throughout the entire life span, there could be little argument about the value of these accomplishments. To die at age 50 of pneumonia or at age 21 from an inflamed appendix was a tragedy and the

prolongation of life for such individuals into their 60s and 70s was a contribution of immense value to individuals, their families and society. However, the prolongation of life beyond age 70, 80 and 90 presents a different set of problems, both physical and mental. If medical science is to be helpful to the elderly, it must address that salient issue.

For some of our aged the additional years, made possible by improved health services, may be productive and a source of much happiness and satisfaction. For those whose quality of life is satisfactory and whose physical and mental health is reasonably good or as good as can be expected, the additional years may be a plus - an added bonus. For others, the added years may bring pain and suffering with friends and family praying for death as a welcome release. We are gradually moving into a situation in which these two extremes are with us and where we face both. This subject cannot be treated in a useful and constructive way without asking the central question, "What constitutes an acceptable and desirable quality of life for an individual?". We believe the academic and professional disciplines now being developed to study the needs of aging and the aged should be committed to this central thesis. How best can we improve the quality of life for our seniors?

One of the primary ways that life has meaning for most of us is through our relationship with others. Surveys done of the aged indicate that loneliness brought about by a withering away of relationships is an urgent and continuing problem.

Schwenger put it very well when he stated "... what older people want more than anything else, is what the rest of us want — respect, time, concern and caring — i.e., to be treated as human beings ... In the end it is the human qualities of the professional that will determine his future role ... It is in large part, the degree to which we can retain this human quality of the profession, on which will depend the future of all professions in the provision of health care to the elderly in Canada."[5]

Psychiatry, social work, sociology and psychology, and indeed all of the social science disciplines should have much to offer in advancing scientific research which would not only lead to prolongation of life, but even more important, might reveal ways and means of making that life more satisfying and worth living.

Victor Marshall, in the book, Aging in Canada, states "...one of the greatest lacks in Canadian Research on Aging is in the general area of Political Science."[6] Kenneth Kernaghan of the Department of Politics and School of Administrative Studies, Brock University, concludes that aging policy is, and will likely continue to be, determined in very large measure by politicans and bureaucrats at all levels of Canadian government, and he makes this trenchant observation:

> There is a pressing need to promote communication and cooperation in the study of aging among researchers and teachers in different academic disciplines; there is an equally urgent need to stimulate similar interaction between academics on the one hand and policy makers and program administrators on the other. Thus, it is essential to know what potential contributions each discipline can make to the advance of gerontology in Canada and the relevance of these contributions for practitioners in the field of aging.[7]

Unfortunately, academic and scientific research in respect to aging and the aged consists of bits and pieces, none of which are now being tied together. We have not as yet been able to develop in any of the universities or at the government level, a central authority or body committed to the specific task of advancing scientific knowledge relating to the elderly. Other provinces have begun to move in this direction with the appointment of a provincial geriatrician or at least the establishment in one university of a comprehensive department or faculty committed to fostering and developing the entire range of study required in this field.

There are five major issues which require the cooperation of the universities, governments and the private sector if we are to make any

worthwhile advance in respect to scientific research on the needs of aging and the aged and if we are to improve the quality of life of our seniors. These are:

- What constitutes a desirable quality of life for our seniors? Is it prolongation of life? Is it better access to hospitalization, nursing homes and physician services? Is it improved shelter accommodation? How shall we define "well being" for our growing senior population?

- There is a need for a coordinated and forceful thrust in respect to fact-finding, scientific research and all this implies in respect to aging and the aged. We are fragmented at the moment and there are many gaps. Where does the responsibility lie for developing the professional expertise in the field of medicine, the social sciences and law, not only desirable but absolutely necessary in the long run, if we are to improve the quality of life for our seniors?

- Kernaghan refers to the urgent need for academics on the one hand and policy makers and program administrators on the other to come together, or resorting to the language of the day, "to put their act together."[8] It will not be enough for the universities to establish faculties dedicated to the advancement of gerontology if their fact-finding and research is not the direct result of the experience and wisdom of those involved in policy making and program management. By the same token, the policy makers and program administrators will be working at a grave disadvantage without the perceptions that can be provided only by the professional and academic disciplines. Both need each other and the central issue is how to achieve that necessary interaction.

- The fourth issue relates to the investment our universities may be prepared to make in developing research, fact finding, courses of study and training professional personnel to staff the home care programs, nursing homes, hospitals, government departments, and community programs involved in providing services to seniors.

- If rapidly escalating costs are to be controlled, if better productivity is to be achieved for the dollar investment we are making, and if services to the elderly are to be generally improved, we shall have to begin by defining the tasks involved in providing care to the elderly. The next logical step is to ask the question, What kind of professional training and skill are required to carry out these tasks reasonably well? Then, professionals and paraprofessionals should be trained along these lines. Personnel costs are the major costs in the human service professions. It is important then that professional personnel be assigned tasks commensurate with their skills and expertise so that maximum productivity is achieved. The cost implications of professional personnel performing tasks for which they are over-qualified are very great, to say nothing of the serious negative effects on staff morale.

REFERENCES

1. Mary Jo Bane, Here to Stay (New York, Basic Books, Inc.) 1976.

2. Cohe Schwenger, "Professionalization of Health Care for the Aged". Canadian Journal on Aging, Vol. 1, Nos, 1 and 2, Toronto, 1982. Pages 66-71.

3. Ibid.

4. Ibid.

5. Ibid.

6. Victor Marshall, Aging in Canada (Don Mills, Fitzhenry and Whiteside, 1980) p. 5.

7. Kenneth Kernaghan, Politics, Public Administration and Canada's Aging Population. Reprinted from Canadian Public Policies, Vol. VIII, No. 1, Winter, 1982, pp. 69-79.

8. Ibid.

CHAPTER SIX

POINTS FOR DISCUSSION

Social welfare, health and housing programs, whether federal, provincial or municipal, have been developed gradually over many years. There have been few significant attempts to define the respective roles of the public and private sectors. Long term planning is especially significant in the development of services for the aged and aging because of the large numbers involved and the ever increasing magnitude of the problems being faced.

The costs of health and social welfare services have risen so rapidly in the past decade and the demand for new services has become so insistent that we cannot afford further growth and development without the best possible social planning. Effective social planning should be concerned with defining the proper role of the three levels of government in relation to each other and to the private sector, and with identifying and defining priorities in the lengthy shopping list of needs which are constantly being placed before government for consideration.

We will attempt in this chapter to summarize for discussion purposes, the main issues that are confronting us now and which will continue to face us during the next decade. A few of these have already been referred to in Chapters three and five. We have broken these needs and issues down under appropriate headings such as health, housing, income support and pensions. We have tried to analyze the subject matter in such a way that those planning new programs will have as much information as possible before them. A plan of action may then follow.

The shape of that plan and the form which it should take should come first from the community, if at all possible. It is important that seniors and young peeople both take an active part in that discussion. The costs of some of the options may be onerous, and these will fall primarily on the working population;

we are all involved and we should therefore all play a part in finding good answers and good social policy directions.

HEALTH - GENERAL

Chronic Care

We are using the phrase "chronic care" to mean type 3, or extended care, rather than type 2, generally referred to as nursing care.

Health needs increase dramatically with advancing years and because the number of the very old, especially women, is increasing, the need for chronic care continues to increase. Notwithstanding the discharge policies in acute care hospitals, a number of chronic patients are being cared for on a long-term basis in these facilities. Various estimates have been made of the number of such chronic patients and some place the figure in excess of 200.

It is estimated that about 100 guests in nursing homes require chronic or type 3 care. The presence of these guests in the nursing home system raises obvious problems and issues since the nursing homes are not staffed, equipped or licensed for this level of care. On the other hand, the removal of these guests from familiar surroundings would, in some cases be very traumatic. In the absence of an organized program of chronic care, the current mixing of types 1, 2 and 3 patients in nursing homes creates serious problems for all concerned.

All of this leads to the question - Will Nova Scotia have a comprehensive chronic care program for the elderly? If chronic care is to be provided, will it be an extension of acute hospital care under the direction of the Department of Health?

Patients requiring chronic care who are fortunate enough to be in acute care hospitals are automatically covered by the Health Insurance Program. Patients in nursing homes or homes for the aged either pay their own way or become the financial responsibility of the municipal unit of residence, with

provincial cost sharing. Obviously, the continuance of a system such as this is unfair to the senior and to the taxpayer as well.

A specialized program, whether it be an extension of the hospital system or a separate system, will be costly; the annual budget escalation is likely to exceed the growth indicators we now anticipate for the economy. What will a specialized program cost now and over the long term? Shifting the burden of costs from general revenues to the Hospital Insurance system will not lessen costs and will place an additional financial strain on that part of the health program.

These are questions that have confronted the Departments of Health and Social Services for several years and they will continue to do so because of the projected increase in the number of the chronically ill and the very old.

It is difficult to estimate precisely the number of empty hospital beds that might be available for chronic care. To further complicate matters, these beds are not necessarily located in the areas where there is the greatest need.

There are two options open to the Departments of Health and Social Services:

Option 1: Continue with the current program or a modification thereof, in respect to hospitals and homes for special care, recognizing that there are chronic care patients in acute care hospitals, nursing homes, and homes for the aged, and utilizing empty hospital beds for the care of such patients where possible. In the absence of a specific program, community pressures are bound to continue for additional beds.

Option 2: Develop specialized facilities for chronic care of the elderly as an extension of the acute care hospital system.

Sooner or later, government will be required to decide whether the costs of chronic care should be shifted to the Hospital Insurance system. That decision

will not be easy to make, nor will it be easy to administer if made. If chronic or type 3 care were to be shifted to the Hospital Insurance system, leaving type 2 care to be financed as at present, government would immediately be confronted with new problems related to:

- enforcing the definition of types 2 and 3 care,
- increasing numbers of chronically ill seniors requiring beds which are not now available,
- very large increases in costs.

User Fees

User fees have become the subject of debate partly because of the revenue problems all governments are facing at the moment and partly because of real or imagined abuses which are said to beset some health service programs for the elderly. Are user fees a necessary component in our health care system? Should we have reservations about the scale or magnitude of user fees? The federal government, through the Canada Health Act, is now taking a firm position against the principle of user fees for acute health care. The Government of Nova Scotia has made a public pronouncement to the effect there will be no user fees in the hospital system.

Balance Billing

The issue of balance billing has been, and continues to be, the subject of much discussion. The new Canada Health Act proposes to discourage balance billing by deducting from the federal grant the gross amount of such billing. There are substantial arguments both for and against this practice. Generally speaking, the medical profession does not see it as posing any significant threat to the health care system especially to the provision of physician services to seniors. Balance billing remains a significant issue in the provision of health services.

Home Care

Extensive reference is made to the subject of Home Care in Commmunity Services under the heading of Home Life Supports.

Drugs

Seniors need more information about drugs, their effect and their use. In many cases, drugs are prescribed with very limited verbal or written instruction and the senior has little or no knowledge of what can be expected. We are hearing much about the interaction of drugs, foods and alcohol: many seniors lack information on these matters. There is some evidence that drugs are being abused by seniors. What can be done to improve the overall situation?

The cooperation of the pharmacist and other members of the health team, such as the nutritionist and the nurse, is essential if seniors are to be given more information about the use of drugs. To achieve a better understanding of the use of prescription and non-prescription drugs by the elderly, health providers and particularly pharmacists will have to become more active members of the health services team.

The 1982 discussion paper of the Federal-Provincial Working Group on Central Nervous System Drugs makes the following recommendation:

"We recommend that pharmacists in hospitals and community pharmacies continue to recognize their responsibility to provide drug education and counselling to consumers, and when relevant, to other professionals".[1]

The report goes on to state that faculties of pharmacy are providing courses which emphasize the educational role of the community or hospital pharmacist.

Communication and public information is also important. The Nova Scotia Commission on Drug Dependency in cooperation with the Nova Scotia Pharmaceutical Society published a booklet in 1981 entitled Your Medicine and

How to Use It - A Guide for Senior Citizens.[2] We recommend this booklet highly as one of the best available guides for seniors on the use of prescription and non-prescription drugs. Senior citizens' clubs would do well to keep their members aware of such information. All such publications, of course, need to be updated. Radio, T.V. and the daily newspapers are other media for getting information on drugs to senior citizens.

Obviously this general information approach may not solve all the individual problems of drug abuse. It will help, however, and if we could upgrade the role and responsibility of the pharmacist and other members of the health team, we might be able to make a sizable dent in the problem.

Nutrition

Many seniors are suffering from malnutrition. This may be due to a variety of causes. Many elderly persons are unable to feed themselves adequately. Seniors living alone may have little incentive to prepare an appetizing meal; gradually they may develop poor eating habits leading to ill health and malnutrition. These are not easy problems to cope with, either for a senior living at home or in an institution. It is vital to the health and well-being of the senior that this problem be dealt with, especially as more and more seniors require chronic care.

Costs of Health Care

There continues to be a considerable degree of concern expressed by the media and the informed public that health costs are escalating too rapidly and may be out of control. How valid are these concerns? An examination of Canada's expenditure on health care over the past decade shows that although many countries have, during the 1970s, experienced steady increases in the share of national income devoted to health care, Canada has not. In Canada that share has fluctuated around 7.5% during the 1970s while in the United States it has risen to nearly 10%. All health care expenditures in Canada increased from 5.9% of G.N.P. in 1962 to 7.9% in 1981. The comparable increase in the United States for the same period was from 5.6% to 9.8% of G.N.P. It is comforting to note

that the health care system in Canada provides total coverage with little or no possibility of individuals not being covered, whereas the American system provides no such assurance.[3]

Preventive Health Services

Prevention has been the keynote of public health programs since their inception. For example, Pharmacare for the elderly might be considered by some as more sustaining than preventive, but it can be argued that early diagnosis and adequate medication go a long way in preventing further illness and attendant costs.

A similar observation applies to all public health initiatives and the effectiveness of prevention must be measured against the relative costs of individual programs. If preventive health programs are to become more efficient and expand to meet the ever increasing needs of the elderly, this can only be achieved by community initiatives and by the public health regional units working in cooperation with the Nova Scotia Medical Society, the Dalhousie Medical School and other appropriate health and welfare agencies augmented by voluntary initiatives on the part of the elderly and their associations. This is particularly true in the field of mental health where, if gains are to be made, the entire health services establishment will have to work vigorously together to achieve that end.

Palliative Care

The subject of palliative care is dealt with extensively in a pamphlet issued by the Policy, Planning and Information branch of the Department of National Health and Welfare in September 1982.

A sub-group of the Federal-Provincial Working Group on Special Services in Hospitals, defined palliative care as follows:

"Palliative Care" refers to programs or services that provide care to those patients for whom treatment aimed at cure and prolongation of life is no longer appropriate but for whom therapy aimed at improving the quality of the remaining life is the primary objective. Palliative care offers therapeutic services designed to address the physical, psychosocial and spiritual needs of dying patients and their families".[4]

The quality of life of the terminally ill is attracting attention all across Canada and has been the subject of extensive coverage by the media. One of the definitive works on the subject is a publication entitled "Death and Dying" by Dr. Elizabeth Kubler-Ross.[5]

The issue arises because of the dramatic improvement of the quantity and quality of our health services over the past two or three decades and the fact that life expectancy has been greatly lengthened. Seniors are living longer and we now have the professional and technical knowledge to extend life to a point where serious questions arise in doing so.

There are two central questions to be considered:

- how to develop appropriate education on death and dying, in training schools and in continuing education programs; and
- how to rationalize the continued prolongation of life if that life becomes devoid of all meaning and quality, and treatment is continued without the permission of the patient?

Assessment of Geriatric Patients

Geriatrics is one of the many specialties developed in the practise of medicine over the past two or three decades. Its importance is related to the fact that people are living longer and the numbers of the very old are increasing and will increase even more dramatically during the next two or three decades. It is not unfair to observe that the health service establishment including the medical

schools and the medical profession, has been slow to recognize the importance and value of this newly developing specialty. Far too many continue to view old age with a rather pessimistic outlook.

Only now are we beginning to realize that it is important that we pay attention to the health needs of the old and the very old.

As the specialty of geriatrics becomes more highly developed and as more geriatricians become available for consultation, we should be concerned with making the best use of their expertise. One way of doing this is through the development of assessment centres where geriatric patients may be admitted and provided with total assessment of their physical and mental condition and what long term care is best suited for them. Only by a thoroughgoing assessment service can we hope to ensure adequate care of seniors and efficient use of scarce resources.

Pharmacare Costs

The rapidly increasing costs of the senior citizens' pharmacare program should be considered. In the fiscal year 1978-79, the actual expenditure was slightly in excess of $12 million. The estimated cost of this program for 1984-85 is in excess of $36 million for an increase of 300% over a six-year period. This cannot be accounted for by inflation. Certainly this annual cost increase, which is far in excess of population increase, in excess of increases in the costs of living and in excess of economic growth, should cause all of those interested in the program to pause and ask why and where is it going? The increase cannot be attributed to the fact that the program has not matured. It has been in force since 1974.

HOUSING

Conversion of Apartment Units to Condominiums

The conversion of apartment units to condominiums may create considerable hardship for seniors in rental accommodations where such changes are being

made. The pros and cons of such conversions are complicated and beyond the scope of this paper. The issues require further study by government, seniors' organizations and real estate agencies.

Rent Control

Legislative control of rents is a matter of great concern to seniors and their families. Perhaps no other issue evokes greater controversy and disagreement between those who view controls as an urgent necessity and those who believe controls interfere with the free enterprise system and in the long run do more harm than good. A Royal Commission has reported in respect to this matter and rent controls will be continued in Nova Scotia.[6] The only relevant issue for seniors therefore will be the administration of the controls and their effectiveness in maintaining rents at prices seniors can afford while at the same time ensuring a reasonable return to the real estate owners.

Community Awareness of Housing Needs

There is an unfortunate trend in society towards having government initiate new programs for people, programs which on completion become the subject of criticism because the results may not be precisely what were expected or wanted. The private sector and government can best meet the housing needs of the elderly when senior citizens' clubs and organizations become concerned and actively participate in deciding what their needs are and then make these known. This kind of group action enables seniors to find solutions on a community basis to their own problems without undue dependence on government. It also encourages the private sector to play a more constructive role in meeting the housing needs of the elderly.

These observations lead to two views of how seniors' housing needs should be met. One view is that government and the housing specialists know best what is required and they should get on with the job of meeting needs. Consultation and the involvement of community groups would only delay or at least would not greatly assist in the final result.

The other view is that extensive communilty involvement, especially of seniors, will ensure that what is done is relevant to current needs. This provides greater assurance that the final result will be acceptable to the community and to seniors themselves.

Home Repairs and Family Home Programs

As seniors who own their own homes become older, they become less and less capable physically, mentally and financially of looking after the maintenance repairs required. The fact that women tend to live longer than men and seniors overall are living longer to the point where chronic illness may overtake them, aggravates the problem.

Each additional month a senior can remain in his or her own home and community means one month less of institutional care; this is extremely important from a humane and a financial point of view.

Ninety percent or more of all seniors are living in their own homes, in rented accommodation, or with relatives. In some cases the family home may be sufficiently large to accommodate the father and/or mother, provided financial assistance is available for minor structural alterations. These arrangements should be encouraged by government as a necessary adjunct of a comprehensive home life supports program.

The Department of Housing is now placing a high priority on home repairs for seniors' housing and providing financial assistance for minor structural adjustments to enable seniors to live with relatives.

Housing Design and Access-A-Home Programs

Because seniors are living longer, many develop disabilities of one kind or another which can make it difficult to live in a private home or apartment unless modifications are made in the design and structure of the housing unit. Modifications in housing design and structure would make it possible for disabled

seniors to remain in the community for a longer period of time and are a necessary component of a comprehensive program of home life supports.

Share-A-Home

The Secretariat has had several phone calls concerning the practicability of the Share-A-Home concept. There are a number of seniors living alone or senior couples living alone in houses which have the potential for accommodating more than one or two persons. Compatibility would, of course, be the major factor in the success of a Share-A-Home project. The need, practicality and cost effectiveness of such a program requires further study.

The Senior Citizens Centre in Dartmouth is now engaged in a demonstration project which began in the early summer of 1983. So far the program has met with a considerable degree of success. The Secretariat suggests that senior citizens' clubs and councils, municipal government and all interested in developing home life supports for the aged, should study the Dartmouth project, the administrative structure of that program and its degree of success in having seniors remain in their own community, thus avoiding institutionalization.

Fact Finding Study Concerning Senior Citizens' Public Housing

We have noted that the Department of Housing, with the cooperation of Canada Mortgage and Housing Corporation and the municipal government, has constructed and made available more than 5,550 senior citizens' housing units strategically located throughout the province. These units are managed and administered by some 45 local housing authorities. The local housing authority operates under legislation established by the province through the Department of Housing. Rentals are subsidized and the admission of seniors to housing units is determined by the local housing authority. Because of the rental subsidy, local housing authorities incur substantial deficits. In view of the magnitude of this program, its relevance to comprehensive home care rather than to institutional

care, and its cost to federal, provincial and municipal governments, it seems appropriate to have an in-depth study of the following topics:

- the need for new and additional subsidized housing units for seniors
- the strategic location of additional housing units
- admission procedures
- rental charges and arrangements
- design and location of housing units for better coordination with Homes for Special Care.

The location of additional housing units raises a number of conflicting aims and objectives. Generally speaking, seniors want to live somewhere near centres of activity and not in isolated areas off the beaten track. This has always been a controversial point in deciding the location of Homes for Special Care. Inexpensive land may be the deciding factor in the selection of a site but locating a facility for seniors on such a site may provide little or no opportunity for community activity. At the same time, seniors do not want to be too far removed from their home community. A county or region as a whole may have sufficient nursing home beds. However, one specific population area in that county may feel that its seniors are too far removed from the centre of population where the beds are located so that visiting is difficult and the surroundings are strange and unfamiliar to the senior. How do we reconcile these conflicting requirements in deciding where housing units for seniors should be located?

It has been said that bureaucratic procedures, whether in the public or private sector, should be perceived to be fair as well as being intrinsically fair. One gets the impression that there is a considerable degree of public cynicism in respect to the admission procedures for senior citizens' housing. Whether this is justified or not is impossible to say. A study would do much to restore public confidence in these procedures and if there are inequities, recommendations might be made as to how these could be remedied.

The system of rental charges was established many years ago and it is questionable whether it is in keeping with current market rentals and the income maintenance structure. An in-depth study would be helpful in coming to grips with this issue.

Senior citizens' housing in Berwick has been located adjacent to the nursing home. Cooperation between the two units has enabled seniors to pay for meals in the nursing home if they so wish. This system has the advantages of enabling seniors to remain in their own apartments for a longer period of time than might be possible if they had to get their own meals. Moreover, such apartment units may be located in an area where a Meals-on-Wheels program is impractical.

Security

Security is increasingly becoming a matter of concern for the elderly. The problems which it creates are likely to increase rather than diminish.

Insecurity is not confined to seniors in senior citizens' housing, but is general. There is no single strategy that may be relied upon to solve the problem although there are a number of strategies that should be considered.

Tenants living in an apartment block should become involved in their own security and have their own organiztion to effect it. Caretaker personnel can be helpful, of course, but tenants should be able to do much to help themselves.

In the larger community the police and Postal-Alert are helpful and obviously much might be accomplished by seniors and their friends and neighbours getting together on a block basis and working cooperatively with the postman, the local police and other community agencies.

Electronic surveillance may be practical in an apartment block; however, it may be too expensive for an individual to afford.

INCOME SUPPORT AND PENSIONS

Universal Versus Selective Programs

The choice between universality and selectivity continues to be an issue in the provision of income security programs. What are the merits of each, considering the resources available for implementing seniors' programs? What trade-offs have to be considered?

If the financial resources were available, the arguments in favour of universal programs would be overwhelming. They have the advantage of not drawing the line between the haves and the have-nots. They are not divisive in the sense that they set up two categories of citizen - one which receives the benefit and one which does not. There is no reason for the citizen to be evasive and attempt to get around the system, because, everyone is eligible. Finally, the administration of universal programs is generally less expensive and certainly less distasteful to the general public since the principle of "right" is an integral aspect of the program. The practical effect of universality of payment is that some who receive the benefit do not need it. That, of course, is the main objection to the universal approach.

Selective programs, on the other hand, are divisive by their nature. They divide the community into the haves and the have-nots, those who are eligible for the benefit and those who are not. No matter how well a selective program is structured, there is a built-in tendency towards it being a disincentive and very often the program invites the citizen to find ways and means of evading the strict letter of the law.

However, the simple facts are that we cannot afford universal programs of any magnitude and we therefore have to resort to a trade-off situation in which we try to have the best of both worlds to whatever degree this may be possible.

Realistically, seniors' organizations and citizens generally have to decide what they want and what they are willing to pay for. If we are unable to pay for universal programs, then we have to accept selective programs and minimize their disadvantages.

Selective Income Support - Tests of Eligibility

If we opt for selective income support programs rather than universal ones, what kind of selective tests should we use in determining eligibility and how should they be administered?

There is a wide range of choices. The early Poor Laws were distasteful generally because the applicant was pauperized before becoming eligible for assistance. Policy decisions concerning the structure of selective eligibility tests should be based not on emotional generosity but on choices in which disincentive in respect to work and savings is minimized and the individual is encouraged to provide self-help to whatever degree is possible. Costs and efficiency of administration are key factors.

Impact of Selectivity Versus Universality on Current Health and Social Services Programs

What impact, if any, would a greater degree of selectivity of access have on current health and social service programs?

It is perhaps theoretical to debate whether certain universal programs might be made selective, thus effecting considerable financial savings. Public opinion is not likely to be tolerant of such changes which are perceived to be a less excellent way of doing things. We have referred elsewhere to the impracticability of terminating or drastically altering health and welfare programs. That also applies here.

Pensions

The Nova Scotia Royal Commission on Pensions and the Federal Green Paper on Pensions are detailed and comprehensive in their discussion of this subject. We shall do no more here than summarize the issues.[7]

Reforms of the pension system should be effected in the areas of indexing, vesting, portability, adequacy and coverage. How far-reaching and extensive will these reforms be? Will we lock in, or vest, contributions from the first payment or at the end of the first or second year? Is it practical and feasible to plan now for complete portability of pensions? Is indexing in whole or in part, practical and financially and actuarily sound? What are the limitations of the private pension system in achieving total or near total coverage? Is it possible to place more emphasis on survivor's benefits? These are just a few of the questions and issues that have to be resolved.

The central issue relates to whether or not we have a mandatory system of pensions, how and by whom should it be administered and the adequacy and coverage. Personal initiatives through the private sector and the tax system have played an important role in providing income security for elderly Canadians. However, experience has demonstrated that only a limited number of people have taken advantage of such programs sufficiently early to provide a substantial degree of income security for later years. Would the numbers increase substantially if the private pension system were reformed and brought up to date? Is the only way out of the dilemma some form of mandatory coverage either under the Canada Pension Plan or private pension plans, or a combination of both?

The financial and human proportions of the problem will not grow less. As the number of Canadians reaching retirement age increases, the demand for income security will increase proportionately. If substantial reforms are effected in the private pension system, to what degree would this increase the number of Canadians providing for their own income security through private pensions? Undoubtedly there would be some increase but it is doubtful that it

would be substantial. If that is so, financial responsibility for those lacking adequate pensions would fall entirely on Old Age Security and the Guaranteed Income Supplement and, of course, on provincial Social Assistance. This is not a satisfactory long-term solution for a problem of this magnitude.

There are those who hold that while private pension plan reform is necessary and desirable, it is unlikely to provide a satisfactory solution for the growing problem of income security for elderly Canadians. They argue that if there is to be a mandatory pension plan, the compulsion should be exercised through the public sector and the Canada Pension Plan.

The solution of their choice is the extension of the Canada Pension Plan to provide universal and compulsory coverage for all Canadians. The current Minister of National Health and Welfare has publically supported this option.

If we move in this direction two central questions have to be addressed. The first relates to costs. Can we achieve comparable results with comparable costs by relying solely on broadening the scope of the Canada Pension Plan rather than by working for the same results through the private sector? Second, what are the costs of full and complete coverage under the Canada Pension Plan likely to be? What effect will these additional costs have on business and industry and the wage earner, who will be paying through deductions? In the long run all such costs are passed along and therefore affect prices of consumer goods. Even more importantly, they affect the capacity of Canadian business to be competitve in foreign markets.

These are difficult questions for which there are no clear-cut, simple answers.

Disincentives in Housing and Social Service Systems

Many social service programs have built-in disincentives which are difficult to remove. For example, Family A sets aside financial resources for old age, thus enabling the senior to pay his or her maintenance in a nursing home. Family B

makes no such provision and the senior, on placement in a nursing home, becomes wholly dependent on subsidies from the municipal, provincial and federal governments. What effect does this and other disincentives have on saving, personal independence and the individual's willingness to plan and save for old age? If there are disincentives such as this in social service programs, how can they be corrected?

Many of the disincentives we are concerned about cannot be effectively removed without spending large sums of money, or failing that, reversing social policy in such a way that would likely be wholly unacceptable to the public.

If government decided that chronic care (i.e. extended or type 3 care) should come under the health insurance program, this would in effect move the problem down to the next levels of care. The dimensions of the problem would be lessened but we would still have guests in homes for special care who pay until their assets are used up while others in the same facility, who have made no provision for their old age, receive care at government expense.

Another option would be to make all types of care a government responsibility under an insurance scheme. This kind of universal approach would be so costly that it would be impractical at this time.

Responsibility for Providing Income Security

The responsibility for providing income security has gradually evolved over the years. The Mothers Allowance program in 1930 and the Old Age Pension program in 1933 represented the first federal and provincial involvement in the provision of income security for certain categories of Nova Scotians. At that time it was understood that these payments did not purport to meet individual need fully. They were payments towards meeting individual need with the

understanding that if the amount of the payment was insufficient, the recipient would supplement it from some other source such as earnings or private charity.

Public expectations have changed greatly since that time and most people now expect that programs such as these should meet individual need fully. Is it incumbent on the public sector to meet need totally when the individual may have failed to make adequate provision for his or her senior years? What do we perceive the role of the public sector and the business or employment sector to be in this regard? How do we define personal responsibility?

Rental Assistance and Property Tax Rebates

The provincial programs of rental assistance and property tax rebates have been well received and it is almost impossible to estimate their beneficial effect in encouraging seniors to remain in their own homes or rented accommodation rather than seeking admission to a home for the aged or nursing home. In short, they have been, and will continue to be, a valuable resource in developing a comprehensive program of home care.

Eligibility for these two programs depends on whether the senior is receiving the Guaranteed Income Supplement. The province has never used an eligibility test other than the test applied by the federal government for the Supplement. Because this does not meet the needs test requirements of the Canada Assistance Plan, there has been no federal cost sharing since the inception of these two programs. It would be expensive and time consuming for the province to devise and apply a needs test of its own. It would also irritate applicants.

The Secretariat is of the view that both of these programs have played a major role in making it possible for seniors to continue for a longer period of time in their own homes and communities and has, to a large degree, lessened the pressure on admissions to homes for special care and institutions. An analysis of individual situations demonstrates this conclusion.

Extension of Spouse's Allowance and Guaranteed Income Supplement

Some women between 60 and 65 are experiencing much financial hardship. The Canada Pension Plan is inadequately funded at the moment; for this plan to remain solvent will require an amendment making additional contributions mandatory from individuals and from business and industry. Extension of the Canada Pension Plan to provide substantially increased benefits for women, while desirable, is still at the discussion stage and considering the current recession and restricted government budgets, is likely to remain there for some time.

Private pension plans have not been totally effective in relieving need amongst our retired seniors. Even if changes are made which require workers to make some provision for their old age, it will take at least two or three decades to see beneficial results.

The most effective interim measure, therefore, in relieving need in this age group would be to broaden the Spouse's Allowance and Guaranteed Income Supplement programs.

A very large number of single women aged 65 and over do not qualify for Canada Pension Plan benefits and, because of the small number of women in the labour force before 1960, the problem of single, needy women aged 65 and over will be with us for some time to come. Those between 60 and 65 are also in a difficult position. The broadening of Spouse's Allowance and Guaranteed Income Supplement programs is essential if the needs of these women are to be met.

While the number of men reaching age 60 and 65 is considerably less than that of women, their financial plight is worsening because of the unemployment situation, the increasing emphasis on early retirement, and the problems all seniors face in finding full or part-time employment late in life (e.g. at age 60). As in the case of women, if the pension system were reformed immediately the benefits would not be available to seniors for two or three decades.

Special Social Assistance

The Special Social Assistance Program was introduced in the spring of 1973 at a time when energy costs were increasing somewhat dramatically and it was felt that special assistance should be available to needy seniors. Originally there was no built-in cost of living factor; the payment remained the same from year to year.

The amount of federal cost sharing received from the federal government since the inception of this program has been relatively small. The total financial outlay has been $71,820,500 up to and including the payment in the spring of 1983 and the total federal cost sharing has amounted to $5,216,240. In the spring of 1979, the government introduced a cost of living factor; the annual payment thus escalated with the cost of living in 1979, 1980, 1981 and 1982. The 1983 payment was made at the 1982 level. The payments which began at $110, $100, $75, and $50 are now $219, $197, $146 and $109.

Some criticisms have been levelled against the program. The major one is that only recipients of the Guaranteed Income Supplement are eligible to apply for the Special Social Assistance payment. The critics argue that the G.I.S. income test is too restrictive.

The estimated cost of making the payment universally available would be more than $20 million annually. Another alternative would be to devise an income test separate and apart from the Guaranteed Income Supplement income test applied by the federal government, perhaps raising the income levels somewhat. Both alternatives have been considered by government and neither are affordable. The program, even as it stands, places a heavy financial burden on the provincial government, necessitating an expenditure of $10.5 million yearly with limited federal cost sharing.

The purpose for which Special Social Assistance is being paid has never been specifically identified. When it was first granted in 1974 there was some

general thought that it would assist in defraying increased energy costs. The payment continues to be viewed as a form of cost of living supplement. If the justification for the payment in 1974 rested on increases in the cost of living, the best that can be said for it is that it constituted a stopgap or interim measure designed to be replaced eventually by a permanent program, or by increases in Old Age Security and the Guaranteed Income Supplement. If it was designed as a stopgap program it would be difficult from a logical and rational point of view to justify the continuance of this payment for 10 years, let alone beyond that.

The lack of federal cost-sharing constitutes a serious drawback especially in the light of the estimated cost for 1984 of $10.5 million.

The 1984 payment, if made, will be the eleventh. Does this program represent the best use that can be made of a provincial expenditure of $10.5 million? Is the need for which the payment was made in the first instance and for which it is being paid now, a high priority? Could the Special Social Assistance payment be diverted to other needs of seniors which should have a higher priority?

We have referred in other sections of this report to the fact that once health, welfare and housing programs are in place, they are difficult to change; yet, if existing programs are never terminated, where will government find the revenues for the development of new programs which perhaps have a higher priority? This is a serious question and it requires serious study.

Family Income

Eligibility for many federal and provincial programs is determined on an individual basis; thus there may be several persons living together in a family home with two or three or more receiving assistance from the federal and/or provincial governments. For example, a mother may be receiving provincial assitance either on behalf of children or because of a disability while the spouse is receiving Old Age Security and the Guaranteed Income Supplement. Other members of the family may be receiving Old Age Security and there may be still

other disabled members of the same family receiving provincial Family Benefits. The gross income in these situations may be far in excess of that being received by other families in the community where the head of the family is a wage earner.

Other jurisdictions are examining the possibility of dispensing with individual eligibility insofar as the husband and wife are concerned. In other words, if the assistance is being paid on the basis of a needs test, the husband and wife are considered as one single unit. The merits of this approach require careful consideration.

COMMUNITY SERVICES

Home Care

Coordinated Home Care has been defined by the Nova Scotia Council of Health in its 1972 Report as "a level of care which is an alternative to and extension of hospital and other institutional care whereby the medical, social and ancillary services of health and health related personnel together with the resources of many agencies combine to function for the maximum benefit of the patient treated at home".[8] This definition stresses the health component of home care.

The fact is that although ill health very often means that seniors leave their own homes and communities and enter an institution, the actual support services required to maintain home care are largely in the Departments of Social Services and Housing.

We do not have an overall, coordinated program of home care in Nova Scotia although there are a number of home care services already in place. There is a provincewide program of homemakers in the Department of Social Services provided through voluntary agencies and municipal social service departments and funded largely by the Province. The public health nurses in the Department of Health provide some home nursing services. The VON, operating in some parts of the province, also provides home nursing for seniors.

Two home care demonstration programs were initiated by the provincial government in Pictou and Lunenburg counties in the fall of 1981. It was hoped these two pilot projects would supply answers to some of the basic issues, such as costs, management procedures and the need for such a program. Unfortunately the economic recession and restricted budgets have resulted in the delay of provincewide implementation and in the meantime the two pilot projects are being continued.

In Pictou County, the homemakers program is delivered by Family Services of Eastern Nova Scotia and the VON provides the home nursing component. In Lunenburg County, the Family and Children's Services of Lunenburg County deliver the homemaker services and since there is no VON in that county, the home nursing component is provided by the provincial community health nurses.

Each of the programs in both counties is being coordinated by a community-based committee with representatives from the Departments of Health and Social Services. Each Department maintains supervisory and financial responsibility for its own program. The Secretariat was assigned the task of coordination.

Home care is defined in the Manual of Policy and Procedure for the Pictou and Lunenburg demonstration projects as "a coordinated service delivery network which meets the needs of people who require assistance or support in performing the daily activities of living and/or health maintenance at home".[9]

Four important conclusions emerged from these two pilot projects:

1. If seniors are to be helped to stay in their homes, three Departments - Health, Housing and Social Services - have to work closely together in providing home life support services.

2. A wide variety of voluntary home life support services are required from the community to encourage and assist senior citizens who wish to remain at

home. For example, errands may have to be run to keep a home in operation. There is often a need for transportation to church, doctor's office or shop areas. Social activities and telephone reassurance are essential. In the winter there is a need for snow removal. Seniors' day care may play an important role. The lack of an adequate amount of these community services often forces many elderly Nova Scotians to go into a home for special care.

3. It is essential that one department of government be charged with the responsibility of providing the necessary coordination and leadership if we are to have an efficient delivery of the required support services.

4. A coordinated approach to home life support services is a broader concept than home care, and in addition to health services, requires housing helps and a wide range of other community support services.

We believe the phrase "home life supports" reflects more accurately what is required if home care is to be made a practical alternative to institutional care. The word "care" has a somewhat narrow connotation, implying what happens to the individual in the home setting. Examples are visits from a doctor, or nurse, solicitude from friends, checking by telephone, or vigilance on the part of family. Home life supports, on the other hand, imply a broad range of support services in the community which are essential if seniors are to live at home. Ordinarily one would not think of snow removal, errand running or transportation aids as essential requirements for home care; however, the use of the phrase "home life supports" implies a broad range of services which are required to enable the senior to remain in his or her own home.

Home life supports may be defined as a coordinated service delivery network to meet the needs of people who require assistance or support in performing the daily activities of living and/or health maintenance at home. Home life supports make appropriate services available to the senior so institutionalization is not the only option.

In practical terms, home life supports include everything and anything seniors, community, churches and government may do to make it possible for seniors to remain in their own homes and communities for as long as possible. In this context, snow removal from driveways and from sidewalks where seniors live would be an important aspect. Other services such as Seniors Helping Seniors, day care centres, transportation aids, telephone reassurance, handiman services, errand services, Meals-on-Wheels, Wheels-to-Meals and respite services, make a most important contribution to home care. The list of things individuals, groups and communities can do to enlarge and enhance the positive impact of home life supports, depends entirely on imagination and creativity and on a commitment to the notion that, where feasible and practical, home care is preferable to institutional care.

Much has been written and spoken in the last two decades on this subject. The four Western provinces - British Columbia, Alberta, Saskatchewan and Manitoba - have all developed extensive and far reaching home care programs. New Brunswick has followed the example of New Zealand in developing a program entitled "Extramural Hospitals" or "Hospitals Without Walls". It is essentially a comprehensive home care program under the administrative direction of the Department of Health and organized in the same manner as the hospitals in that province. Social Services is also involved through a community based service program which is responsible when the patient is discharged from the Extramural Hospital Program. The purpose of both programs is to prevent institutionalization.

Experience in other provinces and in the pilot projects in Lunenburg and Pictou Counties demonstrates the necessity of the involvement and cooperation of health, social services and housing if a home care service is to achieve its objectives. Health-related problems are present in 10-20% of the cases to which service is being given in the pilot projects in Lunenburg and Pictou Counties and it is the view of those responsible for admission of clients to the system that health-related problems are often a precipitating factor leading to institutional care in a hospital or a nursing home. The experience gained in the pilot projects

indicates the need for extensive involvement of hospital administrators on local management and admission committees.

The costs of a comprehensive home life supports program would, of necessity, be great. In 1982, annual home care costs in British Columbia were $68,759,000; in Alberta $18,100,000; in Saskatchewan $18,380,000 and in Manitoba $18,600,000. The Homemaker Services in the Nova Scotia Department of Social Services are now costing $1,875,500.

One may assume that the community health nurses in the Department of Health are now providing some measure of home nursing services for seniors. However, a full scale home life supports program covering the entire province would undoubtedly mean a large additional annual expenditure in health, social services and housing. For a considerable period of time this would be a new expenditure and it would be in addition to the costs of maintaining nursing homes and acute care hospitals. Although one might expect some decrease in costs over the years as a comprehensive coordinated system of home life supports gradually falls into place, there would be no immediate reduction in costs.

The decision facing the province, particularly the Departments of Health and Social Services, in respect to home life supports will be difficult and challenging. There are two options:

Option 1. <u>The Departments of Health and Social Services may continue as at present, slowly and steadily increasing the number of hospital and nursing home beds</u>. Past experience indicates that even if the number of hospital and nursing home beds remains relatively constant, the cost escalation of these two items will annually exceed any anticipated annual economic growth. Finding the necessary revenue to finance current programs will therefore be difficult. The inevitable increase in available beds and the additional costs thus incurred will aggravate an already difficult situation.

Placing a freeze on additional hospital and nursing home beds may seem to be a short-term solution but that provides no answer for the increasing

numbers of chronically ill elderly persons who will certainly require additional care in the years immediately ahead. If an effective, provincewide home life supports program is not made available there will be irresistible pressure for additional hospital and nursing home beds.

It may be argued that the home life supports which are now in place will alleviate some of these pressures. This may be so, to some degree, but if these supports in health, social services and housing are to be effective they should be coordinated and extended. There is no coordination at the present time.

Option 2. Nova Scotia emulate the example of British Columbia, Alberta, Saskatchewan, Manitoba and New Brunswick and develop a comprehensive, coordinted home care program or, using the term we have suggested, a home life supports program.

Pursuing this latter option on an incremental basis, which would be the only practical course to follow, would not mean that institutional care would suddenly become unnecessary or diminish to an appreciable extent. The end result would be a mix of institutional and home care.

We have emphasized that coordination of an overall home life supports program is essential if we are to receive the maximum benefit from the resources now being invested. The experience in those provinces which have initiated a home care program would indicate there are four options for achieving coordination. Responsibility for coordination may be assigned to any one of the three departments involved - Housing, Health or Social Services. The fourth option would be the establishment of a Commission or administrative body, independent of the three departments, primarily concerned with the development of home life supports.

The Secretariat has canvassed these options and suggests that if a home life supports program is developed, the Department of Social Services should be responsible for its overall coordination. That department is extensively involved

in encouraging and assisting voluntary community agencies. A large part of a home life supports program will require this kind of expertise and commitment.

Development and Support of Voluntary Services

It is obvious that a home life supports program would require the extensive development and support of voluntary community services for the elderly. There are some support services which government should finance and operate but they are other major services which can best be developed by the private sector.

Some important initial steps have been taken by seniors which are essential for any such voluntary development. There are more than 180 senior citizens' clubs in the province at the moment. Some of these are enthusiastic and very well organized. There are also 12 councils which serve to bring the clubs together periodically. Federal funding through New Horizons grants has been largely instrumental in encouraging the development of these clubs and councils and they provide a substantial form of community development and a base for extending voluntary effort on behalf of seniors.

In addition, three provincewide, nongovernmental organizations are seeking to advance voluntary effort for seniors. These are Canadian Pensioners Concerned Nova Scotia Division, Inc., the Federation of Senior Citizens and Pensioners of Nova Scotia, and the Gerontology Association of Nova Scotia.

The Victorian Order of Nurses is one of the oldest and most prestigious of our voluntary organizations and has had a long record of providing services to seniors in their own homes. The Department of Health is purchasing the services of the VON in the Pictou County Home Care demonstration project. If a home life supports program is to be implemented in Nova Scotia, one of the major policy decisions which government must make will relate to the role of the VON in providing community nursing care.

A few of the Children's Aid Societies are providing homemakers services and have also become involved in making other limited services available to the

elderly. The Red Cross has also been active in providing homemakers services, particularly in the Halifax area. Martha Home Health Care in Antigonish is successfully demonstrating a home care program.

A number of church sponsored agencies have become involved in various aspects of home care. The church should be one of the key nongovernmental organizations promoting services to seniors. The Canadian Legion is an active, Canada-wide service organization with extensive resources whose original membership now has a large percentage of seniors, augmented by younger associate members. The Secretariat is actively pursuing ways and means of having the Legion and its branches become more involved in providing services to seniors, services that would be an integral part of home life supports.

Labour unions have shown very limited interest in current issues affecting seniors and the provision of seniors' programs. The trade unions could do much to mobilize voluntary activity and community interest if they saw fit to assign a high priority to the involvement of their membership.

These are some of the voluntary agencies now in place throughout the province. If home life supports are to become a reality and if the support and related services required for home care are to be made available to our senior citizens, what role could these agencies play? What should we expect from government - federal, provincial and municipal? Are there some services which can best be delivered by the voluntary, community agency and, indeed, which can only be delivered effectively by the private sector?

Municipal government continues to play a major role in the provision of social services. Homemakers is a good example. It is difficult or impossible to examine the role of the private sector except in conjunction with local government since both serve our senior citizens at the community level and the structure and organization of both are on a community basis.

Transportation services are cited by seniors as a high priority need. Transportation needs for shopping, church attendance and health services are

greater in the rural areas than in the urban areas, but essential in both. The nongovernmental agencies and business concerns responsible for providing local transportation facilities could do much to assist community groups and seniors' organizations in meeting the transportation needs of seniors.

The local community knows better than any centralized government what its priority needs are. Through its citizens, their organizations and municipal government, it can mobilize community resources to meet these needs. They will be met more efficiently, less expensively and in a more caring way as far as the senior is concerned, than if they were provided wholly by municipal, provincial or federal governments. Indeed they are of such a nature that they cannot be effectively provided by government alone.

It may be argued by some that this dependence on voluntary community effort and municipal government will produce an uneven and spotty development of services. That may be so, but the dividends in human and financial terms which flow from community self help far outweigh this disadvantage. Moreover, a community gets and provides the kind of services its citizens want, which are directly related to their willingness to become involved in making the community a better place in which to live.

All of this leads to a final question. What should the role of the provincial government be? Experience has proven that voluntary effort will not develop and prosper without an infrastructure to give it encouragement and momentum. Without moral and financial encouragement, citizens become weary in doing voluntary work and well intentioned efforts eventually come to naught.

Accordingly, therefore, there may be a role for the province funding an infrastructure that would encourage the voluntary agencies to which we have referred. A coordinated system of volunteers, preferably including young people, would thus develop, which would work with the elderly in providing voluntary community support programs such as those referred to in this section. The emphasis should always be on encouragement of local citizen effort, keeping in

mind that the primary responsibility for initiating and maintaining services rests not with government, but with the local community.

The amount of money required would not need to be large. The New Horizons program is ample proof that a modest grant program aimed solely at the encouragement and development of community self-help programs for seniors would be of tremendous benefit in getting new programs underway and in extending those already begun.

Certainly if home life supports are to become a reality, and if, from this program, home care is to be enabled to assume a role at least comparable to institutional care, encouragement and assistance to voluntary services must be assigned a high priority.

Day Care Centres and Day Centres

The phrase "day care" is widely used to describe certain children's programs. Care is defined in Webster's dictionary as "painstaking or watchful attention; a person or thing that is the object of attention, anxiety or solicitude".

In the field of aging and the aged, the literature makes reference to both day care and day centres. A day centre is a social centre where seniors may meet to enjoy a hot meal, play cards, socialize, indulge in crafts and hobbies, or discuss current matters of concern. The more than 180 senior citizens' clubs in the province are a form of day centre since they meet periodically in the community and their programs may include all or some of the items referred to previously. It would not be appropriate to describe these centres of activity as "day care centres". The phrase "day centre" is more appropriate.

Northwood Centre operates a day care program in which seniors who live in their own homes may come to the centre for help with medical and social problems they are experiencing. Day care centres of this type which provide medical and social services are being developed in most of the larger centres in Canada. They are centres where the frail, disabled and chronically

handicapped may come and receive care for a day or a portion of a day while still remaining in their own homes and communities. Obviously transportation is a major consideration in the development of a day care program.

There is good reason to believe that a number of seniors could be encouraged to remain in their own homes and communities for a longer period of time, thus preventing institutionalization in hospitals and nursing homes, if some form of day care and/or day hospital services was available.

The Secretariat views these programs as essential community resources for a comprehensive home life supports program. They would add, of course, to existing costs.

Here and there throughout the province and elsewhere in Canada intergenerational programs have been developed making it possible for seniors to become more actively involved with young people and children. A century ago the extended family, which consisted of children, parents and grandparents, was commonplace. Urban living, apartment dwelling, and modern housing modes have all combined to make this the exception rather than the rule. Children, therefore, grow up having only sporadic contacts with grandparents and seniors. Generally speaking, seniors over 60 years of age have limited contact with children. They are housed separately and in many cases they are separated by great distances. The day centre is one of several community resources that might be utilized to promote intergenerational contacts. There is no reason, for example, why a children's day care centre might not be located in a day centre for the elderly, thus utilizing the services of seniors in caring for the children. We have already made reference to the use of high school students in programs such as snow removal and running errands. High school students could very readily be linked into the personnel involved in the operation of day centres.

Day Hospitals

Day hospitals care for patients and provide treatment during the day. The patient returns home at night.

As with day care and day centres a number of seniors might be encouraged to remain in their own homes and communities for a longer period of time, if some form of day hospital service was available.

The development of such a program, of course, will add to existing costs. The alternative is to continue having more and more of our elderly population living in nursing homes and other places offering chronic care. This, in the long run, is much more expensive than the short-term costs of a day hospital program.

Community Outreach Programs

The Department of Social Services provided a small demonstration grant to two homes for the aged in 1981 to encourage community outreach programs. The grant has been continued for one of these facilities, Valley View Villa, and that nursing home has been most successful in developing a seniors program.

Most homes for special care are centrally located. They have specialized facilities and equipment for meal preparation and service. Their involvement in such community programs as Meals-on-Wheels and Wheels-to-Meals is therefore logical and suited to their resources. The involvement of seniors from the community is good for the home and its guests inasmuch as it tends to keep the home in touch with the community and thus reduce the dichotomy that is inevitable between a community and its institutions. We do not wish to imply that homes for the aged and nursing homes are the only organizations that should become involved in community outreach. Other appropriate community organizations have a similar responsibility.

Respite Care

Respite care may be defined as short-term care (ranging from a day or a week to a month) that enables the primary care giver to have a much needed rest or vacation. Contrary to widely held opinion, a large number of seniors are being

cared for by friends and relatives. When the senior suffers from chronic illness and requires constant supervision and care, the burden falling on the care giver can be very heavy. The provision of respite care in such cases can mean the difference between continuing home care and long-term institutionalization Homes for the aged, nursing homes, and hospitals should, therefore, be encouraged to provide this type of care.

Respite care is one of the many supports that are required to make home care an effective community program. Full use might not be made of respite care without considerable encouragement and a well-organized and coordinated public relations program to make the public aware of this service.

Homes for Special Care

Homes for special care include, but are not limited to, homes for the aged, nursing homes, and residential care facilities. The current system began to develop in the early 1960s. In two decades, we have moved from a situation in which there were few homes for special care and a general reluctance on the part of seniors to use them, to our present situation in which beds are more numerous than the generally accepted guidelines warrant.

Community pressure to have more homes for the aged and nursing homes comes from a number of sources. The argument that these facilities provide employment and constitute a small industry in the community is very often advanced as a justification for their extension. An increasing number of private entrepreneurs view this field as a promising way to make a living especially considering the ever-growing demand for additional beds.

Since costs of care may range as high as $50 - $60 a day, private savings are insufficient and the guests are then forced to apply to the municipal unit for assistance. At times, the municipal unit is placed in the impossible position of having to decide whether guests are eligible or not, although they may have already been living in the facility for several months or years.

These are all central and pressing issues which, uncontrolled, lead to increasing costs for the province and municipal level of government. Perhaps more importantly, continued development of special care beds may be the wrong course to pursue in the long run.

The Minister of Social Services has appointed a Special Task Force to review the entire Homes for Special Care program and that report will undoubtedly recommend a strategy in respect to requirements for additional Homes for Special Care beds and other related matters.

Admissions Systems

Interdepartmental cooperation is becoming extremely significant in the development and delivery of government programs. Provincial departments of government have evolved over many years; each has developed its own administrative structure, relationships and management devices with limited interdepartmental cooperation and coordination. We have one admission policy for senior citizens' apartments under the local housing authority and the general supervision of the Department of Housing. We have another method of admission to acute and chronic care hospitals and yet another for Homes for Special Care. It should be possible to harmonize these admission systems so they are more consistent and less confusing to the client and user of the services.

Adult Residential and Regional Rehabilitation Centres

There are 257 guests over 65 years of age in adult residential and regional rehabilitation centres out of a total population of 1,216. This population is, of course, changing as some guests reach age 65 and other guests are discharged or die.

Many of the guests have been in these centres for years and the facility is viewed as home. For them, change, such as transfer to another facility, would be traumatic and even devastating. On the other hand, it is obvious that

facilities caring for the mentally handicapped may have difficulty adjusting their program to care for those elderly requiring psychogeriatric services.

A long-term plan for those seniors now in adult residential and regional rehabilitation centres should, therefore, be considered in the broadest possible context of planning for the mentally handicapped.

We understand that the role of adult and regional rehabilitation centres will be considered by the Task Force making recommendations regarding homes for special care. It is hoped that this report will provide a long-term strategy and plan for mentally handicapped seniors now being cared for in adult residential and regional rehabilitation centres, homes for the aged, nursing homes, residential care facilities and chronic hospital beds as well as those living in the community.

Elder Abuse

Many seniors are vulnerable and their vulnerability increases with age and the onset of chronic diseases. Abuse is an action or omission which affects people who are vulnerable, and which causes fear, pain, indignity, impairment or other harm of a serious nature. In some cases, the abuse is self-inflicted because the individual is unable or unwilling to provide ordinary self-care. A growing number of seniors are affected by the street criminal and crimes such as purse snatching and petty household theft.

There appears to be limited appreciation and understanding of the extent of elder abuse. Where it is recognized, one encounters resignation and the prevailing attitude that nothing can be done about it.

In many cases, family members prey financially on the senior who is unable to take care of his or her financial resources. In other cases, food and medications are used as punishments to enforce what the care giver considers to be a desirable form of behaviour. Very often gross malnutrition, physical abuse, and emotional indignities are inflicted upon the chronically ill elderly. Because

much of this happens within the family circle, it is viewed with less concern than if the neglect or abuse was inflicted in an institutional setting.

Society, through government, has for many years made legal provision for neglect and abuse affecting children under 16 years of age. Child abuse is being extensively studied and legislation and formalized government programs are in place to prevent and cope with it. The law makes provision for remedial action in proven cases of child abuse. Unfortunately, there are few options open to doctors, nurses, social workers, care givers and citizens where abuse of the elderly is concerned except through the Criminal Code. Very often, facts relating to abuse may seem to be clear-cut but it is quite another matter to obtain legal evidence from a chronically ill senior, especially when the offending party may be a close member of the senior's family.

It is an unpleasant fact that we live in a somewhat violent society. Far too many families solve, or try to cope with their problems by using violence. Children brought up in this atmosphere suffer the violence, abuse and beatings which are inflicted upon them and in turn they inflict violence on their elders. Violence breeds violence and this is probably one of the root causes of elder abuse whether in the home or the institutional setting. Ignorance, of course, is the partner of violence.

The Secretariat suggests that the following steps, among others, be considered:

- A concerted educational program in respect to the nature and extent of elder abuse so that all members of society, particularly human service professionals, become aware of what is happening and what steps might be taken to prevent abuse. The responsibility for this rests with all of us - individual citizens, seniors, seniors' organizations, health professionals, social workers and government.

- Universities and bodies competent to conduct research and fact-finding direct their resources towards determining the nature and extent of elder

abuse. This will not be easy but it needs to be done so that we have facts with which to work.

- A brief, well-prepared statement be prepared on the nature and extent of elder abuse and the existing resources available in the community which may be utilized in alleviating abuse. There is much that we could do to alleviate the situation even now if professionals and the public generally knew the nature and extent of the problem and were aware of the resources available at the moment to cope. We do not yet have this information except in bits and pieces.

- Involve the media to a much greater extent than we have to date. This cannot be achieved unless we have facts at our disposal. The media has done much in the past decade to focus public attention on child abuse. It could also do much to focus attention on the nature and extent of elder abuse.

- More extensive involvement and communication between the police and community organizations concerned with elder abuse and security for the elderly. A major aspect of elder abuse is the growing volume of crimes, for example, purse-snatching. We have already made reference to security and the concerns which all seniors have in respect to their personal safety and well-being. The police can help in this area.

- Programs similar to Neighbourhood Watch be introduced involving young people. We have referred elsewhere in this report to intergenerational programs. Extensive use is being made across Canada of Neighbourhood Watch in respect to security for children. We need similar programs for seniors, and young people could play a most useful role in their development and operation.

- A central registry on elder abuse at the provincial or national level. Such a registry has been used extensively in obtaining information on child abuse, disability and similar social problems. At the moment, professionals and

others confronted with elder abuse have no mechanism for reporting what is happening. The police may act if the situation is serious, but more often than not there are no grounds for prosecution, and most of these incidents, no matter how serious, pass unnoticed. A central registry would not solve the growing problem of elder abuse, but it would enable society to have a clearer understanding of the nature and extent of the problem and thus a greater appreciation of what may be required by way of legislative response.

The Involvement of Seniors in Social Policy and Decision Making

We have already stated that this paper is being prepared, not as a series of government recommendations, but rather as a discussion document for seniors to use in focusing and targetting their priority needs. The assumption is implicit that no single response can address all the possible human aspirations and needs of seniors. Even a casual examination of the range of services needed and the complexities involved in determining priority needs indicates how difficult it will be to involve seniors in these social policy decisions. Unfortunately, many seniors are reluctant to become involved. Often those who do become involved speak only for their own point of view and fail to represent the broader community and the greatest need.

The fact remains that meaningful involvement of seniors in the decision-making process is desirable and a goal toward which governments and all constituencies of the private sector should be striving.

The Role of the Church

A growing number of churches and church-going Nova Scotians are asking the following question: What can we do as individual church supporters and churches in meeting the needs of seniors? The question cannot be easily answered. Any attempt to find answers raises a number of unsolved issues.

The first and obvious responsibility of the church is to minister to the needs of those seniors within its own membership. If there is creative and

compassionate leadership within the church, a satisfactory seniors' program should not be too difficult to achieve at that level.

We have already referred to the transportation needs of seniors. If the church is to be helpful to the senior it may wish to think seriously of providing transportation to and from its services and meetings.

Not the least of the issues facing the urban church is the growing parking problem which becomes more difficult each passing year and adversely affects the attendance of seniors at church services and meetings.

For many Nova Scotians, especially the older generation, the church has been, and should continue to be, the focus of their activities while they are able to live in the community. The church should, therefore, consider its role for its senior membership as one of alleviating loneliness and insecurity, visiting the sick and dying, and wherever possible, making the church a pivotal centre of friendship, caring, concern and involvement.

We will refer later to the role churches might play in dissimenating public information and developing positive attitudes about aging and the aged. The responsibility for this rests with the entire church membership; obviously, however, clergymen have a unique opportunity and a special responsibility. If this is to be done well, theological colleges and seminaries will need to devote more attention to the specialized knowledge being accumulated in the field of aging so that the clergy have the best and most up-to-date information available.

A number of churches are wondering if their obligation extends to the larger community outside their own membership. Churches are often strategically located and church buildings may be in use only a few hours during the week; considering the need for seniors' activity centres, it may be appropriate to question whether the churches might play a more prominent and active role in providing services to seniors.

Voluntary activity requires direction and a well-organized, staffed and financed infrastructure if it is to be successful. Here and there sporadic voluntary activity may flourish, but if permanent programs are to be organized and maintained, meeting these requirements is a necessity. Buildings and a few volunteers are not enough to guarantee success in community outreach on the part of the organized churches. Some infusion of money would be required for professional staff and this would have to come from the community, the church or government or from all three.

Community outreach on behalf of seniors by church organizations is needed and, with effort and dedication, could be turned into an exciting and practical venture in community service. It will, however, require outstanding leadership which is abundantly available, but often difficult to mobilize, within the church.

LEARNING OPPORTUNITIES AND LEISURE ACTIVITIES

Provision of Information in the Public Schools on Aging and the Aged

Some individuals and groups maintain that there should be more information in the public school curriculum about aging and the aged. Learning in the educational system does not come exclusively from the curriculum. Teachers convey and impact their own stereotypes to students who are at an impressionable age. Students also learn from their peers in the school system. The elimination of negative attitudes is just as important or more important than the introduction of new material. The first thrust, therefore, should be towards eliminating myths and stereotypes from the current curriculum where it touches on matters relating to the aged. The second effort should be made in the teachers' colleges to ensure that prospective teachers have an understanding of what is involved in the process of aging and of the role seniors could play in our society. These are positive approaches which do not require adding material to the public school curriculum or taking time away from what we commonly refer to as the basics.

Life Long Learning

One of the most productive ways of ensuring good physical and mental health of seniors is to provide opportunities for their continued involvement in the community and their continued personal development. The courses of study offered by the universities to seniors, the adult education classes sponsored by the Department of Education, the financial grants available through New Horizons, and the initiatives of the Department of Culture, Recreation and Fitness are of inestimable value to seniors.

Much good would be accomplished by expanding such life-long learning opportunities, thus ensuring that a diversified and attractive range of learning opportunities are available to seniors to provide for their personal development and to enhance their opportunities for continuing community service.

Pre-Retirement and Retirement Planning

Retirement at age 65 for some seniors may be a welcome release from drudgery or from an unpleasant work environment. For others it is a traumatic and destructive experience. How often have we seen friends who were in the best of physical and mental health retire from the active work force and in a few months lose all interest in life, in living, in the community and in themselves. A growing number of industries are preparing their personnel for their inevitable retirement from the active work force. The Civil Service Commission and the Department of Education are to be highly commended for their work in this field and companies like Maritime Telephone and Telegraph have set excellent examples for others to follow.

Labour unions in recent years have been involved and active on behalf of workers in respect to wages, salaries, and working conditions. There is some evidence that unions are becoming concerned and interested in preparing their members for retirement and pension entitlement. This is a welcome shift in emphasis and we would hope that the trade union movement would become

actively involved in pre-retirement and retirement planning so that when the inevitable separation from the normal work force arrives it will not be as traumatic and destructive an experience as at present. Moreover, labour unions should give more attention to the plight of the retired worker in respect to part-time employment and job opportunities, especially in the early retirement years when the individual may be fully productive and capable of being involved in work activity.

Insurance companies operating in the private sector have a unique and special responsibility in the area of pre-retirement and retirement planning. The insurance industry in Nova Scotia has already taken some positive steps in this direction and the industry is to be commended for its interest in and concern for this area of responsibility.

The Department of Education has provided leadership in pre-retirement and retirement planning. While private enterprise should bear the major responsibility, there is much that the Department of Education can do to coordinate these activities and provide a clearing house for information.

Intergenerational Education Programs

There is a very grave danger that programs will be developed exclusively for senior citizens, which may lead to a kind of undesirable and self-defeating segregation of the elderly from the rest of society. Educational and self-help programs should be designed to cross intergenerational lines and involve young people wherever possible and practical.

There have been a number of useful and constructive examples of programs which cross intergenerational lines and make use of voluntary youth services. The Dartmouth Senior Citizens Centre has developed such programs as has the Senior Citizens Information and Service Centre in Halifax. We believe the resources are available and all that is required is creative community leadership to bring the needs of seniors to the attention of young people and

conversely day care for children is a rapidly growing need which is expensive, the primary requirement being good personnel. We see no reason why more effective use could not be made of seniors in the provision of day care services. The location of day care facilities in proximity to or in conjunction with senior centres would facilitate such productive intergenerational efforts.

Government may exert some degree of leadership in promoting these trends. However, the main impetus and thrust must come from the private sector. New and creative programs will thus be encouraged which provide for intergenerational effort and make use of the life experiences of the elderly as well as the dynamism and creativity of youth.

Elderhostelling

Elderhostelling has become a popular and widely respected program of learning activity for seniors. Governments at all levels and the private sector should carefully consider ways and means of encouraging the Elderhostel program.

Work Opportunities for Seniors

Creative and productive use of the talents and expertise of retired persons on a voluntary or paid basis is an essential ingredient in maintaining the physical and mental health of some retired people who have been active during their life and who wish to remain reasonably active in retirememt. For seniors with limited or no outside income and who would therefore qualify for the Guaranteed Income Supplement, the existing regulations under which the supplement is paid, work as a disincentive. Senior citizens' clubs and organizations have repeatedly made recommendations urging that the two for one formula on which the G.I.S. calculation is based should be amended, permitting larger personal earnings and a lesser reduction in the amount of G.I.S. for which the senior is eligible.

Not all seniors want to be involved in formal work opportunities after retirement. Some need remunerative work to maintain a minimum standard of living; others are only interested in voluntary work.

The development of work opportunities for seniors is not unlike the challenge of unemployment facing Canadians at the moment. The challenge will require the imaginative and creative efforts of the entire community and the support and encouragement of government at all levels. We need to develop voluntary community programs such as seniors helping seniors, handyman services and a host of related programs. These can only be successful if they are based in the community and if they are developed in response to community needs with community involvement.

Government can assist in coordination and in the provision of start-up funding but would be ill-advised to assume direct responsibility for what must originate in the community.

Two directions have to be considered. First, we should recognize that some seniors want to continue working after age 60 and 65 and need money to maintain a decent standard of living. The social policies determined by government in respect to such matters as income tests for the Guaranteed Income Supplement and employment policies should take these needs into account. Otherwise, we are creating a climate in which seniors who want and need to work are forced to depend on what may very well be inadequate welfare payments. Second, voluntary activities enable seniors to place their energy, knowledge and wisdom at the disposal of other seniors in the community and this should be encouraged.

RETIREMENT ISSUES

Mandatory Retirement

The growing problem of unemployment is bound to have a direct effect on the issue of mandatory retirement. When there is an abundance of job opportunities for younger age groups, society can afford to follow a very generous policy with respect to retirement. Unfortunately prolonged unemployment creates pressures that will no doubt adversely affect the concept of abolishing mandatory retirement.

A number of American firms, notably Travellers Insurance Company, have developed creative ways of coping with the retirement issue. Retired employees wishing to work are given special assignments upon retirement. Others fill in during summer vacations. Every effort is made to continue the employee's association with the company after retirement. Government, business and industry could do much more along these lines, which would have the effect of utilizing the skills and expertise of seniors who want to maintain their association with the work force. In the long run, nothing but good could result from this approach.

Certainly, government at all levels and the private sector could do much to assist seniors by being more flexible in respect to mandatory retirement, especially in situations where the retention of the senior in work activity might enhance productivity and provide skills and expertise that may be in short supply.

The Senior Citizens' Commission has prepared a comprehensive report for the government on this subject.

THE FAMILY

Responsibility of Family for Seniors

What is the significance of family and being familial in respect to the placement of seniors in homes for special care, for example? What should be the degree of financial responsibility on the part of children for the maintenance of parents when the basic income supports of Old Age Security, Canada Pension and private savings are insufficient to provide for the senior?

Are Property Liens Justifiable?

The family home has much traditional and emotional significance for many Nova Scotians. When seniors become partially or wholly dependent on municipal assistance some municipal units impose a lien on the family home. Is this good

social policy? What is fair to all concerned - the senior, the community, the taxpayer and the government?

How May We Design Social Policy to Strengthen the Family?

How may we design social policies which are beneficial to the aged and the aging but which do not tend to weaken or undermine personal and familial responsibilities? For example, could we make a more extensive use of the tax system by providing for such changes as attendant's allowances, parental tax credits, etc.?

Encouraging a Familial Society

Chapter five is concerned with the role of the family in modern society and especially the development of a society in which the old and the very old are loved and cared for by their families. We have already delineated a number of issues which have a direct bearing on family life. (e.g. support of parents by children and tax liens on the family property.)

A familial society is one based on our potential capacities, diverse yet complementary, to act as responsible, self-reliant and inter-reliant persons and citizens, families and communities.

A familial society emerges out of our potential to become more caring and sharing people in our homes and in all the other places where we are working, playing, living and learning together. We are seeing on all sides a tendency to divide and atomize family life. Hence, the future of the family will depend in large measure on the expansion of familial networks to encompass friends and families who may or may not be related to us by kinship. While there is no doubt that service needs will require professionals such as nurses, teachers, doctors and social workers, we have to recognize that the capacities of ordinary people to help and support one another are of primary importance in the long run and all our social policies should be directed towards that end.

If caring and sharing are to be the central thrust of a familial society then compartmentalizing our thinking and our service programs for the old and young should be approached with the utmost caution. We tend to create separate organizations to serve seniors and youth; we develop community organizations for separate disease entities. The best interests of good family life and a familial society will not be served by undue compartmentalization. It is important to the development of a healthy society that youth and old age understand each other and work together for the betterment of the community and of life generally. Youth has much to learn from old age. Old age has much to learn from youth.

The City of Dartmouth has developed programs in the past two or three years in which running errands, snow removal and similar services for seniors have been provided by students from the junior and senior high schools. This program has been most successful and suggests a practical application of the principle we are suggesting here.

The never ending cycle of life is a reality. Children who have experienced love, caring and compassion in their own family, usually develop into parents and community leaders who are able to demonstrate caring and compassion in their own lives and perpetuate these qualities in their own families. The state may intervene in a variety of ways, but none of these interventions are as significant as these fundamental principles by which humanity tends to perpetuate itself.

It is important, then, that the community make a responsible and conscious decision concerning those qualities and values which it wishes to encourage and preserve. If, for example, we believe that self-reliance, personal responsibility, caring and sharing are important, there is no single policy which will achieve this end. Rather, these attitudes must permeate all social policies both in the government and the voluntary sector. Only in so doing can we hope to encourage the development of a familial society in which these values become an integral part of the fabric of daily life.

Governments at all levels, business, industry, and voluntary agencies all continually enact and pursue policies that affect family life and the development of a familial society. Some of the social policies that we develop are good and enhance and support the role of the family. Others tend to tear down rather than build up. We are living in a society in which dependence and interdependence are more and more becoming a way of life. We, therefore, need to promote social policies which encourage initiative, incentive and personal responsibility. It will not be enough to develop health and welfare programs which are little more than handouts.

Encouragement of Family Responsibility and Solidarity

We have referred in a number of sections of this report to the desirability of encouraging home care and more especially, familial responsibility. Under the section dealing with home repairs and family home programs we have noted that financial assistance for minor structural alterations in a home might have the effect of enabling seniors to remain for a longer period of time in the community in their own home environment. There are other broader applications of this concept. For example, a young couple may have limited income and find it difficult or impossible to provide the necessary health services that would be required for a parent or parents to live with them. The end result would be placement of the parent or parents in a home for special care whereas a small allowance to provide for visits from a nurse, for example, might enable the parent to remain in the community for a longer period of time.

The development of financial supports for families who have the facilities and the desire to look after their parents or other seniors in the extended family should be explored as an important facet of home life supports.

PUBLIC INFORMATION AND EDUCATION

Misconceptions Concerning the Elderly

Society continues to foster a number of myths and misconceptions about the elderly which have an adverse effect on the development of services and tend to foster intergenerational tension. How can government and senior citizens' organizations and the community work together to develop a more positive view of the role of the elderly in society and the nature and effects of the aging process?

Information Programs

Seniors have difficulty understanding the health, social services, housing and other community services available in the community and in many cases they are unable to cope with the complexities of the service delivery system we have developed.

There are other lesser concerns. The media too often tends to stereotype older adults in ways that are negative and denigrating. The general public tends to view old age as a disease and not as a natural process. The dignity and value of self-worth and self-importance is denied to seniors when we "do for" them instead of "doing with" them and when we fail to involve them in meaningful aspects of daily life. The separation of the very young and the very old along with the inevitable compartmentalization which is so much a feature of our society tends to set the aged apart with negative connotations to themselves and society. We still foster a number of myths about the aged and aging which add further to their loss of dignity and self-esteem. Attitudes towards sex and the aged is an example.

What can we do to find constructive ways of coping with these issues?

We have not made the most effective use of modern communication devices such as television, radio, the press or computerized information banks

although business and industry use these methods of communication very effectively. The media makes free time available for these purposes. The available resources are not being used to their full extent.

Community groups concerned with the needs of seniors, service clubs, and churches could bring leadership and direction to all of these needs.

The following suggestions are made for consideration:

- Toll free telephone numbers and computerized information banks could be used effectively. Lines of communication should be opened up with press, radio and T.V. so that available resources and time are used to a greater degree. We are doing some of this now and there is ample goodwill to expand what is being done.

- Information leaflets and booklets need to be prepared and distributed on a continuous basis. We have made good beginnings. The Drug Dependency Commission has published a booklet on the use of drugs.[10] Canadian Pensioners Concerned have researched and published an excellent booklet on the law and older Nova Scotians.[11] The Secretariat has published two booklets in 1981 and 1983 entitled, Programs for Senior Citizens.[12] These indicate the initiatives we need to take.

- There is a need for greater intergenerational communication and activities to which we have already referred.

- The clergy and the churches could contribute in developing positive attitudes and eliminating myths and stereotypes of aging.

- Government at all levels could do more to simplify the service delivery system and its complexities.

RESEARCH, EDUCATION AND TRAINING OF PERSONNEL

Development of a Geriatric Centre

There is mounting evidence to show that by the end of this century Nova Scotians, and indeed all Canadians, will be faced with very serious problems in respect to providing care and services for our aged and aging population. It is questionable whether those who will have to bear the full impact of these changes fully understand what will be expected of them in the next two decades. Long-term social planning and the development of sound social policies are difficult tasks. History teaches us that we humans have not been overly skilled or adept at looking ahead and planning for them. Senior citizens and their organizations should, of course, assume the major responsibility in emphasizing the directions which social policies should be taking. However, because seniors view the issues from their own perspective, they may not be entirely objective. The universities, therefore, have a special role to play in training and developing appropriate personnel, conducting research, and promoting sound social policies.

It seems logical that all of the universities, and especially Dalhousie University with its professional schools, should become actively involved in the development of a forward-looking and specialized curriculum that would be relevant to the needs of seniors in the decade ahead. The same challenge and opportunity confronts the Nova Scotia Medical Society, the Nova Scotia Association of Social Workers and community organizations such as the Metropolitan Mental Health Planning Board, representing as they do, the best professional thought in the community.

A geriatrician is a professional physician with a specialty in the field of aging and the aged and diseases related thereto. A gerontologist is a specialist in the field of aging and the aged, but is usually not a physician. A gerontologist may be a psychologist, a sociologist, social worker or a person with professional social science training and education. Competent and well-trained geriatricians are in short supply.

Two competent and experienced clinical geriatricians are now on staff at Camp Hill Hosptial and there are indications that a modern Geriatrics Centre may be developed in that facility. This is most encouraging.

What role should be played by the Nova Scotia Medical Society, the Nova Scotian Universities, including Dalhousie Medical School, the Dalhousie School of Nursing, the Maritime School of Social Work and the human resource professions in promoting the development of an up-to-date Geriatrics Centre such as is now envisioned at Camp Hill Hospital? Would not a centre such as this constitute an essential resource for staff training and development and long-term planning for aging and the aged? Would it not be a more efficient use of scarce resources and less costly for all of us concerned about education, research, personnel upgrading and treatment facilities if we pooled our resources and worked together in a cooperative way?

The suggestion has been made that geriatrics be administered by a separate department both within the hospital and the university. The view is widely held that the specialty of geriatrics will not receive the attention it deserves nor will it be able to function with the prestige it needs unless it is encouraged to function as a specialty and a separate department. The same thinking would hold that geriatrics should be a separate specialty within the hospital setting.

REFERENCES

1. Federal Provincial Working Group on Central Nervous System Drugs, 1982 Discussion Paper, Prepared for and Presented to the Federal Provincial Sub-Committee on Alcohol and Other Drugs. Rec. No. 6, p.9., Halifax 1982.

2. Nova Scotia Commission on Drug Dependency, Your Medicine and How to Use It - A Guide for Senior Citizens, Halifax, 1981.

3. Department of Health Administration, Duke University, Journal of Health, Politics, Policy and Law. Vol. 8, No. 1, Spring 1983, p. 1-43.

4. Policy Planning and Information Branch, Department of National Health and Welfare, Ottawa. Palliative Care in Canada. September 1982. Introduction.

5. Dr. Elizabeth Kubler-Ross, Death and Dying. MacMillan Publishing Company, Inc., New York. Copyright 1969.

6. Commission of Inquiry on Rents, Report, Halifax, 1983.

7. Report of the Nova Scotia Royal Commission on Pensions, Halifax, 1983.

   Public Affairs Directorate, Health and Welfare, Canada. Better Pensions for Canadians, Ottawa, 1983.

8. A Report to the Nova Scotia Council of Health, Home Care, Halifax, November 24, 1982. p.3.

9. Policy Statement Re: Evaluation of Home Care Demonstration Projects, prepared by Senior Citizens Secretariat, Halifax, June 30, 1981.

10 Opus Cit.

11. A Handbook About Federal and Nova Scotia Law and Related Information, The Law and Older Nova Scotians, Canadian Pensioners Concerned, Nova Scotia Division, Halifax, January 1983.

12. Province of Nova Scotia: Senior Citizens Secretariat, Programs for Senior Citizens, Halifax, August 1, 1983.

APPENDIX

THE EVOLUTION OF THE CURRENT SYSTEM

Federal Income Maintenance Programs

The development of Canadian social security programs for the aged began early in the 20th century and reached full force after the Second World War.

The first intervention of the federal government was the enactment of the Government Annuities Act which came into force in September 1908. The object of the Annuities Act was to help Canadians make provision for their later years. The enactment of Old Age Pensions legislation in 1927, the Universal Old Age Pensions legislation of 1952, inflationary pressures and rising interest rates gradually eroded and reduced whatever initial merit and advantages there were in government annuities so that the program is not now considered of any significance in providing income security for elderly Canadians.

The United Kingdom enacted Old Age Pensions legislation in 1908. A Nova Scotia Trade Union, the Provincial Workmen's Association, succeeded in 1908 in having Old Age Pension legislation enacted for Nova Scotia coal miners. Unfortunately, this legislation was not proclaimed and was eventually dropped from the Provincial Statutes in 1923.

The federal Pensions Act of 1919 provided for the payment of pensions to disabled members of the Armed Forces and to the dependents of deceased members of the Armed Forces.

By Orders-in-Council, authorized under a series of annual appropriation acts, the federal government in 1922 began contributing to municipal relief programs on condition that the provinces contribute as well. This first income security cost-sharing program paved the way and established the principle of

federal cost-sharing of an assistance program administered by another level of government.

Thus the stage was set over a 20-year period for Canada to provide old age pensions. That intervention by the federal government occurred in 1927 when the Old Age Pension Act was passed. Nova Scotia enacted enabling legislation in 1933. The Old Age Pension Act provided for federal cost-sharing in the payment of a maximum resource tested pension of $20 per month to people 70 years of age and over. Many Nova Scotians over age 70 refused to apply for the pension because they considered it to be demeaning and pauperizing, a modern version of poor relief which no person with dignity should accept. Needless to say, that attitude towards old age security payments has now completely disappeared.

As of January 1, 1952, Canada's Old Age Security legislation was amended to provide for universal flat rate payments from the federal government of $40 per month at age 70 and resource-tested federally cost-shared Old Age Assistance payments from the provinces at age 65. In 1956, the universal maximum pension was increased to $46 per month and in 1957 to $55 per month. In 1965, the legislation was amended making provision for the age of eligibility to be phased down to 65 over a 5-year period. An income tested Guaranteed Income Supplement was introduced effective January 1, 1967 payable from the federal government in addition to the flat rate universal payment. The purpose of the G.I.S. payment was to provide income tested benefits for people with no or low C.P.P./O.P.P. benefits.

In 1972, all Old Age Security and Guaranteed Income Supplement payments were adjusted annually to the full Consumer Price Index.

Provision for the payment of Spouse's Allowance became effective January 1, 1978. Under this program, the spouse of an Old Age Security pensioner aged 60 to 64, who meets the same residence requirements as those stipulated for Old Age Security may be eligible for full or partial Spouse's Allowance. The amount is determined by an income test.

As of January 1, 1984, the flat rate universal payment amounted to $263.78 monthly and the maximum G.I.S. payment to $265.60 for singles and $204.86 each for a couple. Thus the maximum benefit for which a senior was eligible on that date amounted to $529.38. These amounts are adjusted upwards with the cost of living index.

The Canada Pension Plan enacted in 1966 makes provision for retirement, disability, and survivor's pensions. This earnings-related retirement pension supplements the Old Age Security payment. As in the case of federal Old Age Security payments and the Guaranteed Income Supplement, Canada Pension Plan payments are indexed.

The maximum death benefit payable effective January 1, 1984 under the Canada Pension Plan was $2080. The maximum monthly Survivor's Pension for those under age 65 was $229.18 and for those 65 years of age and over was $232.50. The maximum Disability Benefit payable under the plan in 1983 was $374.50 monthly.

Department of Veterans Affairs

The Department of Pensions and National Health was established by the federal government in 1919 primarily as an adminstrative structure to provide services, allowances, and pensions for the veterans of the First World War. The Department of Veterans Affairs was established in 1944; the original principal focus of its programs was to help veterans of the Second World War return to civilian life.

The Department is divided into four associated agencies, the Canadian Pension Commission, the War Veterans Allowance Board, the Bureau of Pensions Advocates, and the Pension Review Board.

We make special reference to veterans and the Department of Veterans Affairs because veterans constitute a significant part of the senior population. At the moment, 25% of Canada's veterans are aged 65 or older and it is

estimated that by 1985 this percentage will have risen to 50% and to 90% by 1990. Obviously then, the role of Veterans Affairs is of critical importance in the next decade in respect to aging and the aged.

The Canadian Pension Commission administers the Pension Act, the Compensation for Former Prisoners of War Act, and parts of the Civilian War Pensions and Allowances Act.

The Pension Act provides for the payment of pensions in respect of disability or death resulting from injury incurred during or attributable to service with the Canadian forces in war or peace. Pensions are payable on behalf of the dependents of a disabled former member of the forces or to the surviving dependents of a deceased veteran. In 1984, a single pensioner awarded a pension, for disability assessed at 100%, received $1086.22 monthly. The additional monthly pension for his spouse was $271.56 with an allowance of $141.21 for the first child, $103.19 for the second child and $81.47 for each additional child. The pension payable to a surviving spouse was $814.67, with additional payments for dependents.

The War Veteran's Allowance Board, is a quasi-judicial body and provides allowances for individuals or their dependents who meet service eligibility requirements and who, because of age or incapacity, are unable to work and have insufficient income for maintenance as determined by an income test. Veterans of the Canadian forces are eligible if they served in an actual theatre of war, or are receiving a disability pension for an injury or disease incurred or aggravated during wartime service, or served in both World Wars or in Korea or in the United Kingdom during the First World War.

Male veterans become eligible at age 60 and female veterans and veterans' widows at age 55. Eligibility may be considered at an earlier age in special circumstances. Civilians in a number of categories such as Canadian merchant seamen are eligible for War Veterans Allowances.

As of April 1, 1984, the maximum War Veteran's Allowance was $941.68 monthly, with a payment of $113.81 less Family Allowance for each dependent child.

The Bureau of Pensions Advocates provides professional legal aid services to applicants.

The Pensions Review Board provides a review and appeal procedure from decisions of the Canadian Pension Commission in matters of entitlement and awards under the Canadian Pension Act.

In addition to the above, a wide range of services are available to veterans who receive a pension or allowance.

New Horizons

The federal New Horizons program was introduced in July 1972. Its continuance was confirmed in 1975. The program was designed to alleviate the loneliness and sense of isolation that characterize the lives of many older people by making it possible for them to participate more actively in the life of the community. Projects may be funded with New Horizons' money for up to 18 months and there is no upper limit on the amount of a grant. The Nova Scotia budget for the current year amounts to $500,000. The majority of seniors' organizations in Nova Scotia have had the benefit of New Horizons funding for a variety of projects.

Health Services

The Nova Scotia Department of Public Health was brought into being during the fiscal year ending September 31, 1931; the first Minister was Dr. G.H. Murphy. Prior to that, health matters, like social welfare, were assigned to one of the ministers responsible for the traditional departments of government such as Attorney General, Public Works and Mines, and Provincial Secretary. In the following half century, government intervention in the field of health services

made the Department of Health the largest service and spending department of the provincial government. Not only have health services become extensive and costly, they also have a high status in the public estimation. Although government intervention generally may be open to question, few if any people question the need and desirability of extensive government involvement in the provision of health services. Indeed, the reverse is the rule and governments face continuing pressures to broaden existing programs and develop new ones.

From 1931 to 1955, the Minister of Public Health continued to head the Public Welfare programs of the department. In 1936, the Public Service Act provided for the appointment of a separate Minister of Public Welfare. However, the Minister of Public Health continued to hold both portfolios until 1955 when J. Clyde Nunn was appointed Minister of Public Welfare and Labour. The portfolios of Health and Social Services have come under separate ministers since that time.

These two departments of government, by their very nature, provide a number of services which overlap into the responsibilities of the other department. For example, rehabilitation has a major professional component which belongs in health services. At the same time there are service components of rehabilitation which properly belong in Social Services. A growing area of responsibility, the development and management of nursing homes, provides institutional care midway professionally between chronic or extended hospital care and the type of personal care provided by a home for the aged. For several years, indeed until 1970, the licensing and supervision of nursing homes was the responsibility of the Department of Health. It has now become the full and complete responsibility of the Department of Social Services. This does not alter the fact that there is a major health component in the provision of good nursing home care and if nursing homes are to be effectively operated both departments must cooperate in bringing this about.

These two examples illustrate the need for interdepartmental cooperation on a scale quite beyond that comtemplated only a few years ago. When these services were developed, there was little or no overlap or requirement for

coordination. The need grew as departments expanded and new services developed. We have made reference to interdepartmental cooperation elsewhere in this Report.

A hospitalization plan, cost-shared by the federal government under the federal Hospital Insurance and Diagnostic Services Act, was introduced in 1957 and the relevant provincial legislation was enacted in Nova Scotia in 1959. A federal Medical Care Act was passed in 1966 and implemented by the federal government on July 1, 1968. Nova Scotia took advantage of this enabling and cost-sharing legislation to provide a medicare program in 1969. No premiums are charged nor is there a specified user fee. Both the Nova Scotia hospitalization plan and the medicare program were provided for in the Health Services and Insurance Act of Nova Scotia which is Chapter Eight of the Statutes of 1973.

The province introduced a Pharmacare program in 1975 to provide prescription drugs to all residents of Nova Scotia who are registered under the program and are 65 years of age and over.

The community nursing program in the Department of Health has had a long history going back to the thirties when the Department of Health was first established under a Minister of Health. Specified home nursing services are provided through this community nursing program.

Housing

The federal government first entered the housing field in 1918 when funds were made available to the provinces for relending to the municipalities. The first general federal housing legislation was the Dominion Housing Act, passed in 1935, followed by the National Housing Acts in 1938 and 1944. The present National Housing Act was passed in 1954. It was defined as an Act to promote the construction of new houses, the repair and modernization of existing houses, and the improvement of housing and living conditions.

Canada Mortgage and Housing Corporation (CMHC) is the federal agency which administers the National Housing Act. Whereas in the beginning the federal government was primarily concerned with making mortgage loans and insuring loans made by approved National Housing Act lenders, CMHC is now responsible for a growing number of socially-oriented housing programs. Thus, the National Housing Act has been designed to enable more low and moderate income Canadians to own or rent accommodation according to their needs.

An Act to encourage and promote better housing for people in the Province of Nova Scotia was passed on April 28, 1932 and proclaimed on October 1, 1933. The first Commission, provided for in the legislation, was appointed on February 24, 1934 and annual reports made by the Commission date back to 1935. The aims and objectives of the 1932 Act are set out in detail in the legislation. In summary they were as follows:

- to study housing needs in the province
- to make recommendations for the correction of unsanitary and dangerous housing conditions in the province
- to collect and distribute information concerning housing in the province
- to stimulate planning
- to cooperate and work with the municipal government to promote planning and improved housing
- to encourage the formation of companies to build houses.

In 1938, the Housing Commission pioneered the first cooperative housing project under the company name "Arnold". The project consisted of 11 houses at Reserve in Cape Breton, an area which later became known as Tompkinsville. The Commission was placed under the Provincial Secretary in 1950 and in 1966 began reporting to a separate Minister responsible for the administration of the Nova Scotia Housing legislation.

In 1953, an approach was made to the federal government for funds and shortly thereafter a modus operandi was worked out with CMHC under which

8,857 public housing units were built in Nova Scotia from 1953 to December 31, 1982.

While senior citizens benefit to at least some degree from the general housing programs offered by government, some programs have been designed and geared specifically to assist seniors.

The Nova Scotia Housing Commission became The Department of Housing in 1983.

Social Welfare

The federal Old Age Pension Act of 1927 was followed in 1937 by a Blind Persons Allowance Act and in 1954 by Disabled Persons Allowance legislation. All three programs were administered by the provinces with similar monthly payments, resource tests, and administrative procedures. The Old Age Pensions program gave way in 1952 to a universal old age pension, and a program of Old Age Assistance with federal cost-sharing was inaugurated for people between 65 and 70 years of age similar to the old age pensions legislation of 1927. That program was phased out over a 5-year period beginning in 1965; thereafter all old age security payments came under the federal government.

Mothers Allowance legislation was enacted by the province in 1930, providing for a monthly allowance to mothers with two or more children. This legislation continued to broaden in scope until 1956 when it became part of what is now the provincial Family Benefits Act. Mothers Allowance payments were not cost-shared by the federal government until 1958; from then on the Unemployment Assistance Act of 1956, by virtue of amendments, provided for federal cost-sharing of all provincial assistance payments such as Mothers Allowance. These cost-sharing provisions were further extended under the terms of the Canada Assistance Plan in 1965.

The Nova Scotia Poor Law changed little from its inception in 1758 to 1943. Rather than reform the Poor Law it seemed preferable to select groups

such as the aged and mothers with children and to provide for them through special legislation. Provision was made in 1943 for rural municipalities to consolidate their poor districts under one single administration thus alleviating the need for poor district assessments and the multiplicity of administrative procedures that were part of the system. This permissive legislation had little effect.

By 1958, when the Poor Law was abolished, there were 24 rural municipalities consisting of more than 400 poor districts. There were also 42 towns and cities making a total of 66 separate municipal units. The gross expenditures by all municipal units for the maintenance of individuals in poor houses and poor relief amounted to $242,595 in 1957. In 1958, these same expenditures amounted to $282,603. The gross expenditures on poor relief, the maintenance of people in poor houses, child welfare grants to voluntary organizations, and other forms of social welfare by municipal government in 1958 amounted to $1,237,772. The corresponding gross expenditure for the last fiscal year of which we have record (i.e., the year 1983) was $85,400,000. These comparisons will provide some yardstick or measure of the relative status of poor relief in 1958 and municipal social welfare expenditures then and now. There were, of course, no provincial relief expenditures in 1958 except a small amount for the care of the transient poor (people who had not resided in the province so as to gain legal settlement).

In retrospect, it is fair to say that municipal government began to play a significant role in the social welfare field after 1958. Two factors served to bring about what amounted to a phenomenal change in municipal involvement in social welfare:

- significant provincial and federal cost-sharing of all municipal expenditures for administration and assistance payments.
- the development of a corps of full-time, trained managerial personnel at the municipal level responsible for the management of all municipal social welfare programs.

Apart from acute treatment hospitals, there were only a small number of institutions in 1958 that might be considered suitable for the care of aged persons. Several of the poor houses which had developed on a municipal basis in the first half of the 19th century were abominable places, ignored and forgotten by most responsible people in the community. They were wholly financed by the municipal level of government. Provincial standards were lacking except those established by the Inspector of Humane and Penal Institutions as a result of yearly inspections, and even these were minimal since the Inspector had little power to effect changes when such seemed necessary.

Most of the poor houses were located in rural areas, many of them off the beaten path, and with extensive farming operations. It is no exaggeration to recall that some of the superintendents or so-called "keepers" were more interested in the cows, horses, and pigs on the farm than they were in the cleanliness, health and happiness of the residents.

The thrust in the sixties leading to the development of homes for the aged and nursing homes came from three sources. First, Canada Mortgage and Housing Corporation classified nursing homes and homes for the aged as hostel-type accommodation, the capital costs of which might be loaned through CMHC at subsidized interest rates and amortized over a 40-year period. The second factor was the abolition of the Nova Scotia Poor Law in 1958, and the development of a federally cost-shared social assistance program, first under the Unemployment Assistance Act and eventually under the Canada Assistance plan of 1965. Third, by 1965 the development of nursing homes and homes for the aged was an idea whose time had come and the local communities were ready to move from the old ways of providing for the needy in poor houses to develop modern, up-to-date homes for the aged and nursing homes. In that respect, the municipal level of government in Nova Scotia provided outstanding leadership in cooperation with the province and Canada Mortgage and Housing Corporation.

One of the first homes for the aged under the new program was built in Bridgetown in July, 1966. The financing was arranged through Canada Mortgage and Housing Corporation with the three levels of government (federal, provincial

and municipal) participating under the Canada Assistance Plan and Nova Scotia's Social Assistance legislation.

The developing scope of social welfare programs is best illustrated by the budget expansion which has taken place over the past two or three decades. The entire departmental expenditure for the year ending March 31, 1960 was $6,630,600. That increased to $15,263,270 in 1970, to $135,877,200 in 1980, and it is anticipated the expenditure for the current fiscal year 1983-84 will be in the order of $240,000,000. Of course, the devaluation of the dollar and inflation account for some of this increased expenditure but by far the largest part of it has been due to expanding programs and services, especially Homes for Special Care and social assistance payments.